First Year Checkup:

Strategies for a Stronger Public Health Department

Little Hoover Commission

January 2009

State of California

LITTLE HOOVER COMMISSION

January 22, 2009

The Honorable Arnold Schwarzenegger
Governor of California

The Honorable Darrell Steinberg
President pro Tempore of the Senate
and members of the Senate

The Honorable Dave Cogdill
Senate Minority Leader

The Honorable Karen Bass
Speaker of the Assembly
and members of the Assembly

The Honorable Michael Villines
Assembly Minority Leader

Dear Governor and Members of the Legislature:

Californians need an independent public health leader with the authority to act first and foremost as an advocate for the health and well-being of the public.

Policy-makers took a significant step forward in improving public health in the state by establishing a separate California Department of Public Health two years ago. The state must pursue further structural reforms to make the public health department independent from the Health and Human Services agency. It should be led by a physician director, with advice and oversight provided by health and science experts empowered to speak out on public health issues.

The state must prioritize public health as a core component of public safety, equal to fire and police. The leadership of the new California Department of Public Health must forcefully make the case for budget priorities that reflect the department's public safety role. Budget reductions must reflect budget priorities, and public safety must be a top priority.

The department needs greater independence as well to respond to longer term challenges that threaten California's public health defenses. The department's workforce continues to suffer from high vacancy rates in important areas, particularly in its laboratories, which represent a critical defense against the spread of new diseases and new strains of familiar foes. To its credit, the department is working on initiatives to bolster the ranks of its public health professionals, and reaching out to the University of California. It will need the assistance and support of other departments as well as other parts of the state's education systems to achieve its goals.

The Legislature has taken the initiative in pushing the department to reduce healthcare acquired infections though a series of incremental bills. This is an area in which the department should have led the state's efforts to halt the spread of these preventable infections that kill thousands of Californians. The failure of the department to drive this cultural change speaks to political timidity and underscores the need for the director to take on a greater public advocacy role than the leadership has been willing to embrace.

This is an area in which the state has tremendous regulatory authority and an even greater capacity to educate health providers, insurers and the public. The state's public health officer should report directly to the governor, but must use his position as a bully pulpit to speed the cultural change required to reduce these infections, as has been done in other states and countries. The Legislature must exercise its oversight role to ensure the department moves with urgency.

In its first year, the California Department of Public Health has made considerable strides in implementing recommendations the Commission made in 2003 in *To Protect and Prevent: Rebuilding California's Public Health System* and reiterated in 2005. This progress report in no way suggests that the first anniversary should be a finish line, though the Commission emphasizes that further improvement cannot be achieved by the department alone. The challenge needs the support and leadership of the governor and the Legislature.

The department conducted a comprehensive assessment of the state's laboratory capacity and is continuing to work to address issues identified in it. The department is installing an electronic disease surveillance system to track contagious diseases more quickly and efficiently that has the advantage of using technology already in use by many of California's most populous counties. The department also has made progress in expanding the state's emergency response capabilities. Milestones include a statewide assessment of local emergency preparedness, the design and release of a guide for local health officials on responding to a health care surge, ongoing preparedness testing through coordinated exercises, and the development of an emergency operations center within the public health department to enable coordination with state and federal emergency response partners.

The department must build on this progress, which will require improving communication with local health agencies, which are critical partners in delivering public health services to Californians. California's public health officer must be seen as an independent advocate for the public to open the important discussion on how the state's public health and public safety needs can best be met by harnessing all of the state's assets. This will necessitate a frank assessment of outdated organizational structures and relationships as well as opportunities created by new technologies and systems. The result should be a clear delineation of the roles, relationships and responsibilities of all public health partners, including state and local government, non-profit groups, private business and individuals.

The Commission is encouraged that the state's response to its earlier recommendations will lead to further improvements and urges the governor and Legislature to continue transforming the public health department into a strong and effective public health leader.

Sincerely,

Daniel W. Hancock
Chairman

FIRST YEAR CHECKUP:
STRATEGIES FOR A STRONGER PUBLIC HEALTH DEPARTMENT

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Executive Summary

The California Department of Public Health has made concerted progress in its first year of operation toward improving the state's public health and safety under challenging circumstances. Though the environment has grown only more difficult, there is more work to be done.

The department's ability to protect Californians from disease and respond to public health emergencies will depend not only on the leadership in the department, but on the vision and leadership of the governor and the Legislature.

In four previous reports this decade, the Commission pointed out critical gaps in the state's public safety infrastructure, specifically weaknesses in the state's preparedness in light of the threats illuminated by the September 11 attacks. A 2003 study focused on the weakest of these links, the public health system. It found a department hampered by a lack of independent leadership, an inappropriate organizational structure, poor coordination with public health partners, eroding infrastructure and workforce, and difficulty keeping track of public health funding.

The California Public Health Act of 2006 created an independent department as well as an expert public health advisory committee, in part implementing recommendations made by the Commission in previous studies. The new department emerged from the Department of Health Services in July 2007. The department's first months were dominated by moving public health functions out of the Department of Health Services, creating a new management team and setting a course for the new department's future. The new department put in place efforts to address other Commission recommendations as well. This report documents the department's early progress and makes recommendations for how the department should move forward. Continued progress will require legislation. It also will require a commitment by the governor and Legislature to prioritize public health spending as one of the core components of public safety, equal to fire and police, as the Commission has previously recommended.

As part of the public health department's transition from the health services department, the state public health officer, Dr. Mark Horton,

restructured the organization of public health programs to bring greater executive involvement from program-level leaders and led the creation of a strategic plan. The department took the important step of conducting a comprehensive assessment of laboratory capacity that identified workforce as a major weakness in the system. Following the assessment, the department co-created LabAspire, an outreach and training program designed to increase participation and interest in employment in the state's laboratory network. More broadly, the department initiated and secured money for a Leadership and Workforce Development project that seeks to develop the department's workforce competency and leadership.

The public health department now is close to completing development of an electronic disease reporting system to be made available statewide, implementing a Commission recommendation to install a surveillance system to track the emergence of contagious disease. The system, called Web Confidential Morbidity Reporting (Web-CMR), will allow the state to receive reportable disease information from local health officials and clinicians within minutes or hours of a suspected outbreak rather than days, weeks, or sometimes months.

The department also has taken part in statewide planning and training exercises that should strengthen its emergency preparedness capacity. These efforts should continue alongside the creation of the new California Emergency Management Agency, which combines the Office of Emergency Services and the Office of Homeland Security. The public health department has built its own emergency operations center to better coordinate with larger statewide emergency response efforts. In addition, the department has written standards to guide local health professionals in their response to a major emergency, as well as provided corresponding trainings and a public education component. The department continues to work with local health officials on weaknesses that were identified in the assessment.

It was a busy first year under difficult circumstances. Many challenges remain, however, and many of them are beyond the department's ability to address on its own.

California still lacks a strong public health presence and independent public health leadership. The public health officer does not report directly to the governor, and the public health advisory committee is not designed to effectively advocate for and coordinate public health assets and experts. The governor and the Legislature must take the steps for further structural reform, creating an independent public health department reporting to the governor, and empower a public health board that elects its own chair and can provide oversight and guidance to the department's leaders. The public health officer must be Californians'

advocate for public health and public safety, a role that requires the public health officer to speak with boldness when necessary.

California still lacks a clear vision for the scope and framework of public health activities in the state, including the roles and responsibilities of each public health partner: the state public health department, local health offices, other government agencies, nonprofit organizations, private entities, and individuals. The state's public health leadership, with the input of an independent expert public health board, should assess state problems, strategize on how best to move forward, and facilitate coordination between these public health partners. The public health officer and the board should be vocal advocates for policies that improve public health and public safety. California's public health leaders missed the opportunity to drive change in the area of healthcare acquired infections. Instead, it was the Legislature that took the initiative to require health care institutions to demonstrate they have adequate practices to fight healthcare acquired infections and report infection rates to the department, and eventually, the public. In response to each new piece of legislation, however, the department stepped up to the challenge of implementing the new requirements, relying on the considerable expertise of the department's staff.

The state's public health infrastructure – the network of human, physical, and informational resources – continues to erode, in part due to across-the-board budget cuts. Because of these cuts, the department recently closed its immunoserology unit at the state laboratory in Richmond, halting a number of tests that will be redirected to the national Centers for Disease Control and Prevention laboratory. Local public health officials have expressed concern that the delay in receiving results from the CDC will increase the state's vulnerability to disease outbreaks and the spread of multi-drug resistant tuberculosis. Though the state has assessed its laboratory capacity and is moving forward to address the issues identified in the assessment, considerable work remains, including consideration of how public health partners, public and private, can structure local laboratory services to best serve their needs and the state as a whole.

For a number of reasons, the public health workforce suffers from high vacancy rates in certain job classifications, with particularly acute shortages of microbiologists critical to lab bench work. The department has not done comprehensive workforce planning and is only just beginning to track its vacancies, and that at the request of the Legislature. The public health department should be proactive in developing plans to solve current and potential workforce shortages, including collaborating with the Office of Statewide Health Planning and Development (OSHPD) to ensure that data on public health workers is

collected as part of the implementation of the new, legislatively required Health Care Workforce Clearinghouse. Further, the department should use its place as the state's public health leader to partner with local, academic and private industries to identify needs and bolster the department's and the state's public health workforce.

Funding for public health continues to challenge state and local public health programs, which operate in programmatic silos that are burdened with expenditure restrictions and reporting requirements. The state needs to find ways to enhance the flexibility of public health funds so that its limited dollars can be used more effectively. The department has been proactive in this area, working with the federal government to streamline federal funds coming into the state. Once it is successful in doing so, the department should use its funding flexibility to introduce incentives that reward improved public health outcomes. Discussions on appropriate outcome measures should start now, in anticipation of greater opportunities to introduce performance measures into funding decisions.

The creation of the new state public health department is an opportunity to re-examine from top to bottom how California provides public health services and protects public safety from health threats. It should be an opportunity to think creatively and assertively about new ways of delivering these services, the need for creativity made even more urgent given the state's financial straits. Making the department an independent agency would only enhance its leaders' ability to think, and speak, more forcefully on behalf of the public.

California has growing health threats that include drug-resistant tuberculosis, new, highly contagious diseases and the threat of a potential biological terror attack. California also has benefitted from medical breakthroughs and advances in communications technology that allow better and faster identification of pathogens, communication of lab results and mobilization of public health responses to these new threats.

The state can no longer do business as it has in the past, nor should it. Instead, state and local public health leaders together must continue to redesign a public health system, one based not on "what it used to be, but what it *has* to be," in the words of one member of the Commission's advisory committee.

Significant steps have been taken in the last several years to address the Commission's previous concerns, but more must be done to continue to improve California's public health system. The governor and Legislature can lead this effort by giving the public health department and public

health advisory committee the appropriate structure and authority to pave a new road to greater public health and safety.

Recommendation 1: The governor and Legislature should make the California Department of Public Health an independent office, led by a state surgeon general reporting directly to the governor, to act as a forceful advocate for Californians on public health and public safety issues.

Recommendation 2: The governor and Legislature should transform the public health advisory committee into a state Board of Public Health to provide independent advice and guidance to the governor, the Legislature and the state public health officer.

- The governor and Legislature should enact legislation to replace the existing temporary advisory committee with a permanent public health board with the following characteristics:
  - ✓ Members should consist of an equal number of appointees by the governor, leaders of each party in the Senate and leaders of each party in the Assembly.
  - ✓ The board should provide scientific expertise on the department's public health programs and projects and should examine ways to address problems and improve the health and safety of Californians.
  - ✓ The board should report at least annually in writing to the governor and Legislature on the priorities for government action to improve public health.
  - ✓ Appointments should be for fixed, voluntary terms and members charged with the responsibility to represent the public interest and protect the public's health.
  - ✓ The state public health officer should be a member of the committee and should report to the board on a regular basis about the department's activities, regulatory projects, strategic planning progress, special projects, workforce needs and any other similarly critical issues or projects of the public health department.
  - ✓ The board should develop partnerships with California's academic institutions, foundations, and private medical, biotechnology and information technology industries.
  - ✓ The board should meet monthly.
- Until a new advisory board is created, the state public health officer should bolster the stature of the existing advisory committee by:
  - ✓ Convening advisory committee meetings at least quarterly.

- ✓ Allowing committee members to develop the committee's agenda and priorities.
- ✓ Devoting resources to reimburse committee members for meeting-related expenses.
- ✓ Directing the committee to develop an annual report for the governor and Legislature identifying priority areas where state action is needed to improve public health in California.

Recommendation 3: The California Department of Public Health must broaden its efforts to grow and maintain the public health workforce.

- ❑ The department should partner with all three public higher education systems to fill the pipeline for public health workers and to educate and link students with public health opportunities at the department.
- ❑ The department should, on an ongoing basis, assess workforce needs and identify priority areas based on needs, pipeline capacity, and with an eye toward the future of public health practice. The department should work with the Office of Statewide Health Planning and Development in developing its health workforce data collection system to ensure that public health workforce is included in the process.
- ❑ The department should communicate public health workforce needs and proposed solutions directly to the governor and Legislature.

Recommendation 4: The California Department of Public Health should continue to provide leadership to develop the state's laboratory capacity.

- ❑ The department should facilitate consolidation of county laboratories into regional laboratory programs.
- ❑ The department should determine its laboratory capacity priorities and ask the governor and Legislature to help lift barriers to workforce development, such as microbiologist salary structures that cannot compete with private and county laboratories.

Recommendation 5: The California Department of Public Health, with the help of the governor and the Legislature, must create more flexible funding mechanisms in order to provide more efficient and effective services to the public.

- The public health department should review its categorically-funded programs and determine which programs could be consolidated into block grants. Where possible, the department should consolidate program funding and contracts.
- The department should continue to work with the federal government to streamline federal funds coming into the state.

Public Health in California

The demands on California's public health system are enormous. Californians rely on public health officials to protect them from disease as well as ensure the safety of the water they drink, the air they breathe and the food they eat.

From the beginning, public health threats included communicable diseases, such as the bubonic plague that spread through San Francisco in 1900, that required the government to investigate how the plague started, monitor its spread, establish quarantine measures to contain it and develop immunizations to stop it.[1] As the century unfolded, modern science revealed how preventive measures could thwart chronic disease. Public health responded by incorporating health education, screening programs and new vaccines into its scope.[2]

Now, with the reality that terrorist attacks can take place on U.S. soil and new health threats emerging, public health faces new and mounting challenges, whether fast-spreading drug-resistant infections, bioterrorism or the need to launch a wide-scale emergency medical response.

As never before, public health is essential to public safety.

Such concerns about public safety and the role of public health first catapulted to the top of the Little Hoover Commission's agenda in 2001, leading to four studies of public health and emergency preparedness in California.

Following the terrorist attacks of September 11, 2001, the Commission reviewed California's emergency preparedness and concluded in its 2002 report that California's public health system was the "largest single weakness" in the state's emergency response network.[3]

The Commission explored the reasons for that finding in its 2003 study, *To Protect and Prevent: Rebuilding California's Public Health System*. The Commission found that the state's public health leadership and organizational structure were ill-prepared to fulfill the state's obligation to reduce injury and death from public health threats, including environmental hazards, bioterrorism and infectious diseases.

> ***"[Public health is] what we as a society do collectively to assure the conditions in which people can be healthy. This requires that continuing and emerging threats to the health of the public be successfully countered."***
>
> Institute of Medicine, Division of Health Care Services. 1988. "The Future of Public Health." Page 19.

Specifically, the state lacked strong, high-ranking, clearly defined leadership focused solely on public health. As a unit within the Department of Health Services, public health was eclipsed by the health services department's much larger Medi-Cal program, undermining the state's ability to make science-based decisions and partner with local health officers, universities, biotechnology, labs and private sector health experts.[4] The structure hindered the state's ability to prioritize the public safety functions of public health and to provide comprehensive public health leadership.

Prior Recommendations

The Commission found that coordination and communication among state, local and federal public health agencies and their partners were inadequate, and that the state lacked essential expert technical and physical capacities to ensure the best tools and talents are protecting Californians.

To address these findings, the Commission recommended the state improve the effectiveness of California's public health system through specific actions:

1. Create an independent public health department – separate from the Medi-Cal dominated Department of Health Services medical insurance programs – that is focused on emerging threats, with physician and science-based leadership and an advisory board linking California's health assets and experts.
2. Take the lead on coordinating federal, state and local efforts, as well as those of strategic partners, to improve communications, capacities and preparedness.
3. Significantly bolster technical, scientific and physical capacity to make sure the best available tools and talent are protecting Californians.
4. Prioritize public health spending as a core component of public safety, equal to fire and police.[5]

In 2005, the Commission revisited its earlier recommendations to assess the progress that had been made in the state's public health system. It found that the administration had given priority and additional resources to emergency preparedness, but the state needed to take further measures to prepare for large-scale disasters.

The Commission emphasized the following seven public health priorities for the governor and Legislature:

1. Enact legislation to establish a separate department of public health, with physician leadership and with advice and oversight of a scientific public health board.
2. Install a real-time surveillance system that can quickly detect the emergence of contagious disease, whether naturally occurring or the result of bioterrorism.
3. Require an independent and expert assessment of the state's public health laboratory and other essential capacities.
4. Develop an aggressive response to hospital-acquired infections. By December (2005), the administration should propose a plan – endorsed by such independent experts as the deans of California's medical schools – that will reduce the illness and death resulting from these infections.
5. Propose a strategy and a structure clarifying the roles and responsibilities of emergency-related agencies.
6. Lay out a plan for resolving electronic communication problems, including the funding needs and resource plan.
7. Exercise the regional capacity of the Office of Emergency Services to ensure that budget cuts have not diminished the capacity to respond to large-scale events.[6]

A 2006 Commission report, *Safeguarding the Golden State: Preparing for Catastrophic Events,* reviewed the state's ability to respond to a natural or manmade catastrophe and again discussed the role of public health in the emergency response network. The Commission suggested consolidating the Governor's Office of Emergency Services (OES) and Office of Homeland Security (OHS) into a single office in order to avoid duplication of activities and to streamline the state's organizational strategy for emergency preparedness and response. The Commission again stressed the important role the public health system plays in emergency response and urged the state to address integration issues between public health and emergency services.[7]

The Commission's Related Reports

- *Be Prepared: Getting Ready for New and Uncertain Dangers.* January, 2002.
- *To Protect and Prevent: Rebuilding California's Public Health System.* April, 2003.
- *Recommendations for Emergency Preparedness and Public Health.* June, 2005.
- *Safeguarding the Golden State: Preparing for Catastrophic Events.* April, 2006.

These reports are available at: www.lhc.ca.gov.

The State's Progress

In the years since the Commission initially reviewed public health, the state has implemented a number of the Commission's recommendations. Most notable is the Public Health Act of 2006, which created a state public health department to be directed by the state public health officer, and an advisory committee convened by the health officer. By enacting the Public Health Act, the Legislature hoped to achieve these goals:

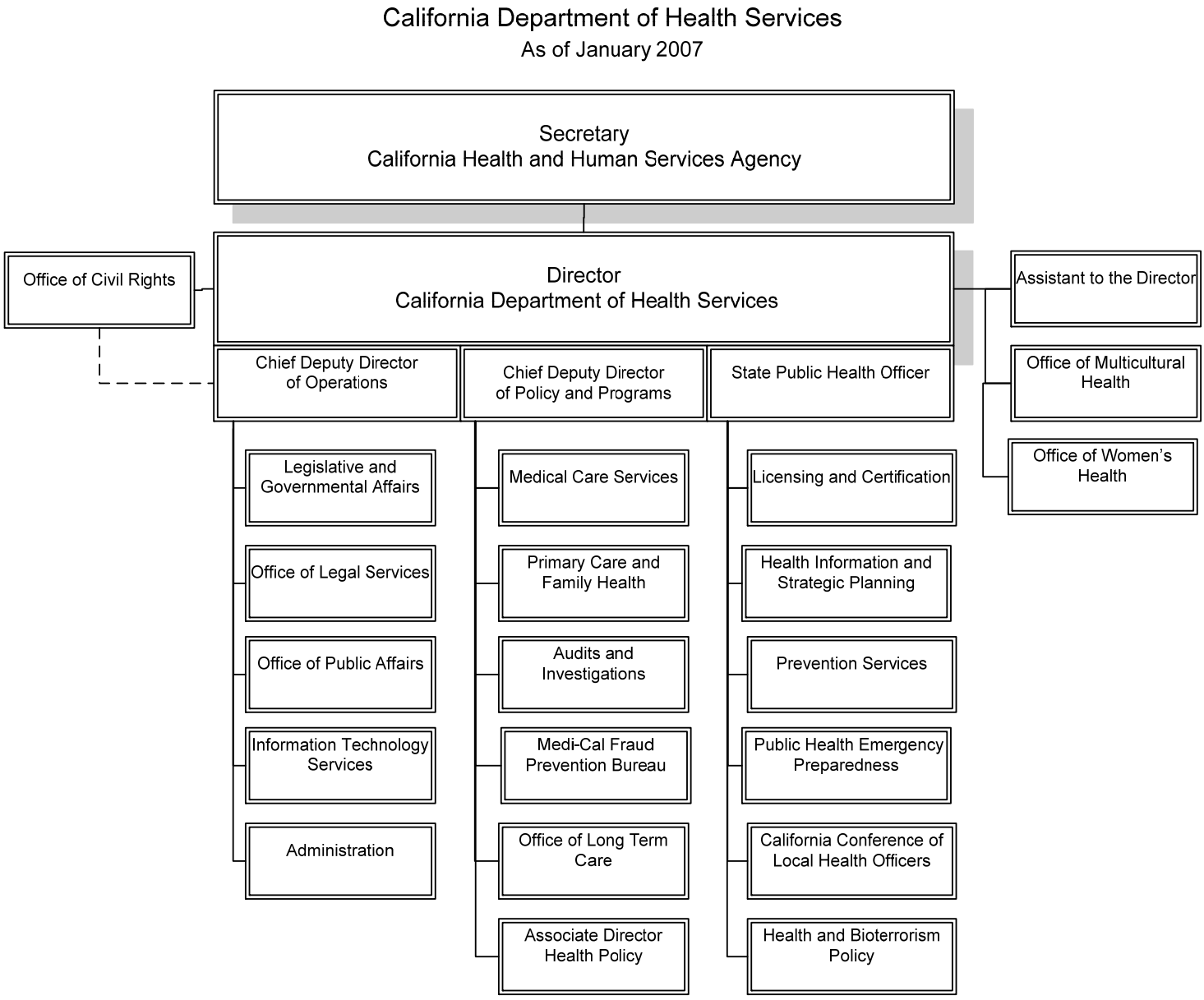
- Elevate the visibility and importance of public health issues in the policy arena.
- Increase accountability and require program effectiveness for the public health and health care purchasing functions of state government.
- Promote the health status of Californians through programs and policies that use population-wide interventions.
- Recruit and retain top quality public health professionals, including physicians, nurses and scientists, who have the requisite education and experience to protect the public health and safety.[8]

California Department of Public Health

Prior to the Public Health Act, the state's public health activities were organized under the Department of Health Services, which administered all health care programs, both medical care and preventive services, within the Health and Human Services Agency. Medical care programs, primarily consisting of the state's Medi-Cal insurance program, consumed 90 percent of its funding and half of all department employees.

To elevate the status of prevention, or public health services, the Public Health Act removed all public health functions from DHS and transferred them to the newly created California Department of Public Health. The remaining functions stayed within the Department of Health Services, renamed the Department of Health Care Services to reflect its more focused mission. These changes became effective July 1, 2007.

The Public Health Act required a state public health officer to be appointed by the governor, subject to confirmation by the Senate. Dr. Mark Horton, then deputy director of public health programs within the Department of Health Services at the time the legislation passed, was appointed and confirmed as state public health officer and director of the public health department.



Though the public health department is still located within the Health and Human Services Agency (HHS), it is now its own department; the public health officer reports directly to the HHS agency secretary in the governor's cabinet. This moved the state public health officer one step closer to the governor in the executive branch structure.

After the separation, the public health officer restructured the department's internal organization and reporting streams.

The public health officer divided Prevention Services into three centers: the Center for Chronic Disease Prevention and Health Promotion, the Center for Environmental Health and the Center for Infectious Diseases.

The public health officer also created the Center for Family Health. This center took on the public health functions of the Primary Care and Family Health program that split off during the separation from health care services.

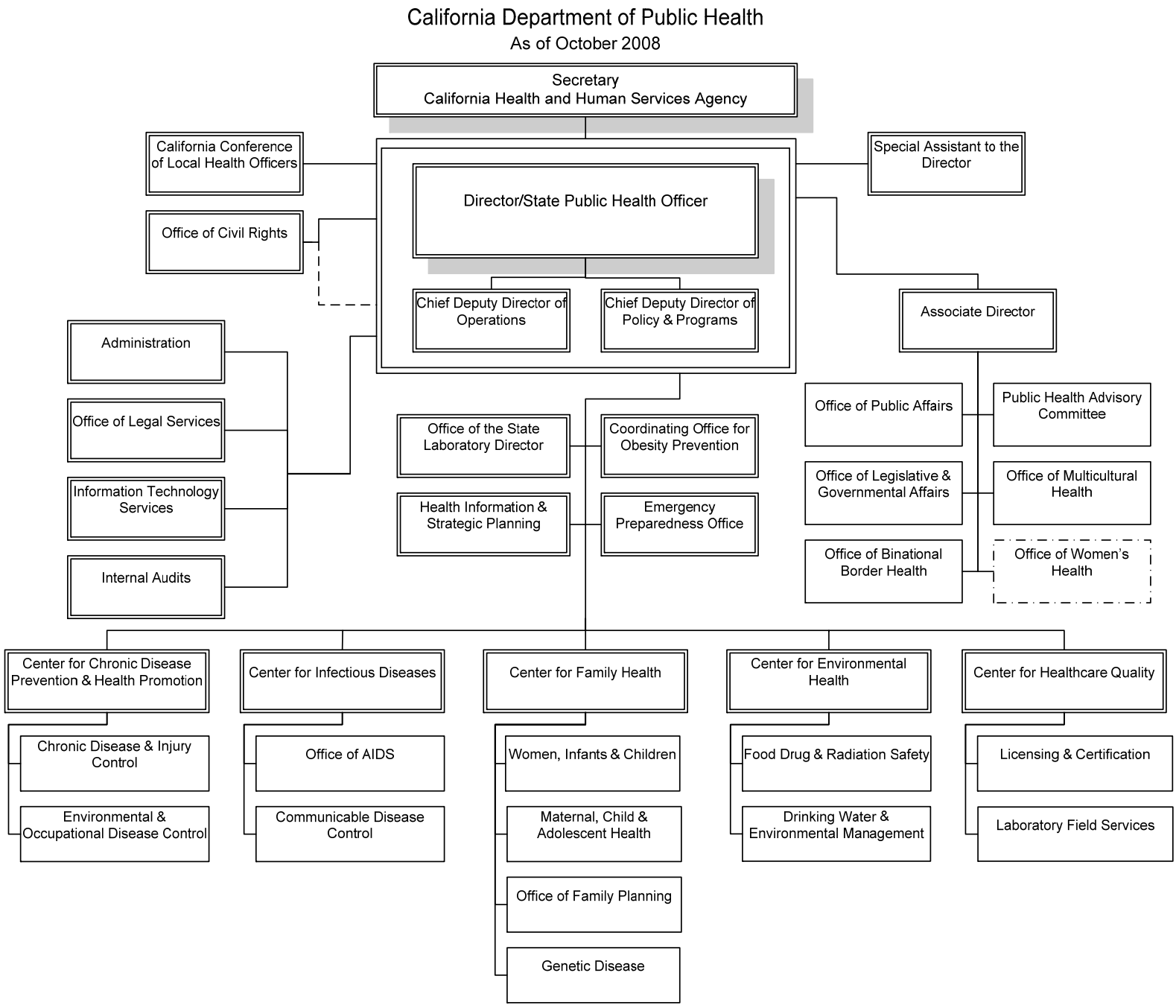
The director combined the Licensing and Certification program with the Laboratory Field Services Branch to form the Center for Healthcare Quality.

With the new distribution of programs into five centers, the public health officer expanded his executive team to include the head of each center. "These smaller centers flatten out the organization and allow the new center deputy directors, as members of the Executive staff, to bring broader and more specialized program input into departmental decision-making and direction setting," the public health officer told the Commission.[9]

To organize obesity prevention efforts that are scattered within several programs, the public health officer took the opportunity to formally establish the Coordinating Office for Obesity Prevention. This division coordinates obesity prevention, physical activity and nutrition issues across all of the programs.

Recognizing the importance of the department's many relationships with other agencies, the public health officer appointed an associate director for external affairs responsible for ensuring collaboration between department activities and public health partners outside of the department.[10]

Choices made in partitioning public health functions from health care services were not always obvious. The Public Health Act defined "public health programs" as "programs and functions that seek to prevent illness and promote health, as compared to programs involving either the direct delivery of health care services or the payment for those services."[11] The Act specified which programs would go to the new Department of Public Health, and declared that all remaining sectors were retained by the Department of Health Care Services.



Many programs cut across both public health and health care services and were not easily severed. In some cases, an office provided both health care-related and prevention-related services, such as the Office of Multicultural Health and the Office of Women's Health. The legislation dealt with these offices by sending one office (Multicultural Health) to the public health department and the other office (Women's Health) to the health care services department.[12]

In other cases, where the legislation failed to articulate a clear division, department officials had to carve out activities and staff or replicate a division, such as in administrative services. To date, some staff report to a contact in another department, and various programs have written agreements to delineate the activities performed by each program in the different departments.[13]

Public Health Advisory Committee

The Public Health Act directed the state public health officer to "convene a Public Health Advisory Committee to provide expert advice and make recommendations on the development of policies and programs that seek to prevent illness and promote the public's health."[14] The new law requires the advisory committee to meet publicly twice a year and include 15 representatives from a broad cross-section of public health stakeholders; nine are appointed by the governor, three by the Speaker of the Assembly and three by the Senate Rules Committee.

The advisory committee was designed to be an internal advisory body for the state public health officer and the administration. It is chaired by the state public health officer, and members serve on a voluntary, uncompensated basis at the pleasure of their appointing authorities and under the direction of the health officer.[15]

The committee first met April 7, 2008, and received an orientation to the process and a presentation of a draft of the new department's strategic plan. Members had the opportunity to comment on the plan and were told that their input would be considered as the department continued to develop the plan.[16]

According to the Public Health Act, the advisory committee will sunset June 30, 2011.

In addition to passing the Public Health Act, the state has taken steps to address other Commission recommendations on public health infrastructure and emergency preparedness.

Efforts to Address Infrastructure Deficiencies

The public health infrastructure in California is an extensive network of federal, state and local agencies, as well as hospitals, clinics, laboratories and other health enterprises. It is comprised of human resources, physical resources and information networks.

The Public Health Workforce. The California Department of Public Health employs 3,500 people in 60 locations across the state.[17] The state has taken several steps to address the Commission's previous concern that the state needed to bolster the technical, scientific and physical capacity of the public health workforce.

To provide a benchmark going forward in addressing staffing levels, the department was asked to report its vacancies to the Legislature annually, beginning December 1, 2007.[18] The department submitted its first vacancy report April 2, 2008, which showed an average vacancy rate of 16 percent and indicated that the department had recently filled some of the vacant positions.

In July 2008, the public health department initiated a Leadership and Workforce Development program with the goal of developing "leadership consistency and a competent workforce capacity to meet the future demand for quality public health services in California."[19] Under the contract, a consultant will develop the following: 1) a plan to establish an Office of Leadership and Workforce Development; 2) an Annual Performance and Development Plan with tools, training and administration; and, 3) survey tools to assess recruitment effectiveness, retention issues, overall employee morale and satisfaction and workplace improvements that are recommended by employees.

After soliciting bids on the project, the contract process was put on hold as a result of the governor's executive order to suspend new contracts in response to the state's budget crisis.[20] The department, however, has made this project a priority and has been able to move it forward despite the initial funding restrictions.[21]

Health Care Workforce Clearinghouse

To address the more general problem of vacancies in the health professions, the Legislature passed SB 139 in 2007. This bill creates the Health Care Workforce Clearinghouse, administered by the Office of Statewide Health Planning and Development (OSHPD), to serve as the central source of health care workforce and educational data and provide an annual report to the Legislature. Specifically, OSHPD's report will:

- Identify education and employment trends in the health care profession.
- Report on the current supply and demand for health care workers in California and gaps in the educational pipeline producing workers in specific occupations and geographic areas.
- Recommend state policy needed to address issues of workforce shortage and distribution.

OSHPD has convened focus group sessions to identify users of the system and the data to be collected and to form partnerships to facilitate data collection.

Laboratory Capacity. California's laboratory system consists of the state public health laboratory and 39 local county or municipal public health laboratories. These state and local laboratories serve the public by screening newborns for various genetic and congenital disorders; watching for disease-producing agents in food, humans and animals; and testing for new threats such as West Nile virus, Severe Acute Respiratory Syndrome (SARS), avian influenza, and bioterrorism. The state laboratory is divided among six laboratory branches: Microbial Disease; Viral and Rickettsial Disease; Environmental Health; Food and Drug; Sanitation and Radiation; and Genetic Disease.

In the new public health department, the state public health officer elevated the Office of the State Laboratory Director so that the laboratory director now is part of the health officer's executive team. The office provides support services, consultation and oversight to the six labs.

In response to the Commission's specific recommendation in 2005 to conduct an assessment of the capacity of the state's laboratory system, the public health department organized a comprehensive review of its laboratory system in coordination with the Association of Public Health Laboratories and the Centers for Disease Control in March 2007. Representatives from state and local public health laboratories, federal laboratories, private laboratories and other health organizations and

10 Essential Public Health Services

In 1994, a national public health committee identified 10 essential services that provide a working definition of public health and a guiding framework for the responsibilities of local public health systems. These essential services provide the foundation for the National Public Health Performance Standards Program led by the Centers for Disease Control to guide and assist state and local public health systems and governing bodies.

1. ***Monitor*** health status to identify and solve community health problems.
2. ***Diagnose and investigate*** health problems and health hazards in the community.
3. ***Inform, educate and empower*** people about health issues.
4. ***Mobilize*** community partnership and action to identify and solve health problems.
5. ***Develop*** policies and plans that support individual and community health efforts.
6. ***Enforce*** laws and regulations that protect health and ensure safety.
7. ***Link*** people to needed personal health services and assure the provision of health care when otherwise unavailable.
8. ***Assure*** competent public and personal health care workforce.
9. ***Evaluate*** effectiveness, accessibility and quality of personal and population-based health services.
10. ***Research*** for new insights and innovative solutions to health problems.

Source: Centers for Disease Control. Office of the Chief of Public Health Practice. National Public Health Performance Standards Program. "Ten Essential Public Health Services." http://www.cdc.gov/od/ocphp/nphpsp/essentialphservices.htm. Accessed October 15, 2008.

providers assisted with the review, which evaluated the system based on the nationally accepted 10 Essential Public Health Services.[22]

The laboratory system assessment gave high marks to the monitoring of health status, informing, educating and empowering people about health issues, and developing policies and plans that support individual and community health efforts. However, the assessment said that the state needed to make significant improvements in ensuring it has a competent workforce to bolster its public health laboratory capacity.

The state public health officer attributed the workforce problem to challenges in hiring and retaining microbiologists due to a shrinking labor pool, low government salaries in comparison to the private sector, the highly specialized nature of the work and the high cost of living in the San Francisco Bay Area, where the main state laboratory is located.[23] At the local level, county public health laboratory directors also are in short supply, as private and academic laboratories pay more than counties for professionals with laboratory director qualifications.[24]

To address the issues identified in the assessment, the department formed a public health laboratory system working group in 2008 to continue to review laboratory system capacity and make recommendations to the department. The group consists of department staff, the state laboratory director and individuals representing local public health laboratory directors, local health officers and health executives.[25]

In addition, the department initiated a laboratory worker outreach and training program in partnership with UC Davis, UC Berkeley, UCLA and the California Association of Public Health Laboratory Directors. The program, called LabAspire, received $2.5 million in the 2006-07 Budget Act to provide:

- Outreach and retention support to UC Davis to attract public health microbiologists and laboratory directors
- Funding to three counties to hire and train assistant public health laboratory directors.
- Money for doctoral candidates to rotate through the Los Angeles and Orange County public health laboratories.
- Post-doctoral training in clinical and public health microbiology at the state's laboratory in Richmond.

In 2008, the first two participants graduated from LabAspire, though neither of them work in a state or local public health laboratory. Seven candidates currently participate in the program, with five of those

expected to graduate in 2009.[26] The program saw its budget reduced to $2.25 million in 2008-09 as part of the state's 10 percent across-the-board reductions.

Electronic Reporting of Communicable Diseases. After the Commission's repeated recommendations for a real-time disease reporting and tracking system, the state finally is close to piloting web-based Confidential Morbidity Reporting (CMR) and Electronic Laboratory Reporting (ELR) systems. Web-based CMR and ELR will move the state from slow and outdated methods for collecting information about communicable diseases from local health officers and providers to an electronic reporting system that supplies information on close to a real-time basis.

This will significantly enhance the state's ability to assess and respond to communicable disease outbreaks such as Avian flu, West Nile virus and illnesses caused by an act of bioterrorism. Currently, county officials report disease information to the state by phone or fax, and only after the county has investigated and confirmed the diagnosis, which may be days or weeks after the initial notification from a hospital, laboratory or clinic. Under the electronic system, county workers and health care providers will enter the disease information online upon the initial contact with the infected patient. The department will be able to access the data immediately. This means the state will receive the reported information within minutes or hours of an outbreak rather than days, weeks or sometimes months.

In 2007, the public health department selected a vendor and entered into a five-year contract to implement Web-CMR and ELR. Staff working on the contract are in the process of configuring the system in preparation for an early 2009 testing phase. The pilot program is scheduled to go live in September 2009.

The vendor selected to develop the state's electronic system is the same one currently used by seven counties in California, including Los Angeles, Monterey, Orange, Sacramento, San Diego, Stanislaus and Yolo counties. Alameda, Imperial, San Bernardino, San Francisco and Ventura counties have developed their own electronic systems and are not affiliated with the state's vendor. The state has partnered with representatives from local jurisdictions to attempt to make the state's system interoperable and fully integrated with these county systems.

Public Health Information Network (CalPHIN)

CalPHIN is a network of information connecting public health partners across the state through multiple programs:

- Electronic Laboratory Reporting (ELR).
- Confidential Morbidity Reporting (CMR).
- California Health Alert Network (CAHAN).
- Lab Information Management System (LIMS).

Though the state took years to plan, gain approval and develop an electronic tracking system, it will benefit from the technological advances and lessons learned by counties that have implemented the electronic system. In addition, health officials in the seven counties using the system are familiar with it and a large portion of the state's population already is being tracked under the system.

A recent complement to the state's efforts to implement electronic reporting is AB 2658 (Horton), signed by the governor August 1, 2008. This new law requires electronic reporting of certain communicable and non-communicable diseases to a state electronic reporting system within a year of the state establishing such a system. Once the state creates the electronic reporting system, public health laboratories must submit the information electronically.

Public Health Emergency Preparedness

In response to the Commission's recommendation to consolidate emergency services, Assemblymember Pedro Nava introduced AB 38 to merge the Office of Homeland Security and the Office of Emergency Services into a single agency. The bill passed the Legislature and was signed by the governor in September 2008. The result is a comprehensive California Emergency Management Agency (CalEMA) responsible for overseeing and coordinating emergency preparedness, response, recovery and homeland security activities in California.[27] The goal of the merger is to clarify lines of authority during emergencies, reduce duplication and conflict that occur between the two offices and improve coordination and communication between the state emergency managers and their local and regional partners.

The governor previously had issued an executive order on April 18, 2006, to strengthen the state and local capacity to effectively prepare for, respond to and recover from catastrophic disasters.[28] The executive order directed the leaders of the Office of Emergency Services and the Office of Homeland Security to convene quarterly meetings with the directors of roughly two dozen state agencies and departments, including the public health department. This group, known as the Governor's Emergency Operations Executive Council (GEOEC), assesses emerging threats to public health and safety, develops plans to improve prevention and response capabilities and assists in the management of emergency preparedness, response, recovery and mitigation efforts.

The public health department, while participating in these larger statewide emergency operations efforts, also has built its own Joint Emergency Operations Center in coordination with the Emergency

Medical Services Authority. The center allows leaders to coordinate field and program activities and emergency aid from local, state and federal agencies on a continuous basis. It is capable of connecting live to the state public health laboratory, the Governor's Office of Emergency Services, the federal Centers for Disease Control and other emergency and public health-related partners. The center is equipped with emergency backup power, emergency satellite and radio communications and a connection to the California Mutual Aid Radio System.

The public health department also has increased efforts to educate the public on how to prepare for emergencies, creating a new Web site, www.bepreparedcalifornia.ca.gov, to provide information to residents, local jurisdictions and other state partners on preparations and resources available before and during emergencies.

Capacity to Respond During a Health Emergency. The Commission's 2003 report identified surge capacity as an area where the new public health department should be given "explicit responsibility to ensure that specific and dependable surge capacity is available." The California Department of Public Health collected data through a statewide assessment of surge capacity and sought to address the gaps that were found.

The department secured $214 million in the 2006-07 state budget for its surge initiative, which included $34 million in federal funds. The department's emergency preparedness office bought supplies and medications in conjunction with the federal strategic national stockpile and developed important surge capacity guidelines for local jurisdictions.

With the state and federal money, the department purchased 3.7 million courses of anti-viral medications, 2,400 ventilators, 50 million respirators, three 200-bed mobile field hospitals, and supplies and equipment for 21,000 alternate-care site beds. The department has made plans for the timely distribution and allocation of these supplies during a catastrophe in coordination with the Centers for Disease Control. In 2007, California received a score of 97.5 percent for its readiness of the state's strategic national stockpile supplies.[29]

In addition to supplies, the public health department developed and released the *Standards and Guidelines for Healthcare Surge During Emergencies*. This comprehensive guide, released in February 2008, details how local health departments, hospitals and health care providers should operate in the event of a sudden expansion of demand on the health care system. The department's emergency preparedness office conducted six regional training sessions on the standards in March and April 2008, and the guidelines have been hailed by local health officers

as incredibly valuable and unprecedented among other states across the country.[30] The public health department also provides an important oversight role by reviewing and providing feedback on surge plans developed by local jurisdictions.

To ensure coordination with private and nonprofit partners during major surge events, the Legislature passed AB 2796 (Nava) in 2008. This new law authorizes the Office of Emergency Services to establish a statewide registry of private businesses and nonprofit organizations that are interested in donating services, goods, labor, equipment, resources or other facilities in times of emergency.

Exercises to Test Preparedness. Since the Commission's initial review of emergency preparedness in 2002, the public health department has participated in a number of exercises and assessments of California's readiness.

The Golden Guardian Statewide Exercise Series, introduced in 2004, has become an annual exercise to coordinate and test disaster prevention, response, recovery and mitigation capabilities of local, state and federal agencies, organizations and private entities. The program provides participants with after-action plans that identify lessons learned from the exercise and gaps where improvements are needed.

In 2006, the California State Auditor found that the exercises up through 2005 had not "exerted sufficient stress on medical and health systems to determine how well they can respond to emergencies."[31] In response, the 2006 Golden Guardian exercise roughly quadrupled the number of hypothetical injuries to increase the level of stress exerted on medical systems.[32]

The 2007 Golden Guardian exercise incorporated a full-scale exercise involving federal, state and local partners in the deployment of California's strategic national stockpile.[33] Health care surge capacity was tested in October 2008, and the department is developing a drill for 2009 that will focus on an influenza pandemic.[34]

Local Assessment. In addition to the Golden Guardian exercises, the public health department collaborated with the Health Officers Association of California to conduct a comprehensive assessment of local emergency preparedness. The goal of the study was to understand emergency readiness in each local jurisdiction and identify areas in need of improvement to guide the state in allocating resources.

The final report was issued in 2007 and identified specific infrastructure needs, areas of relative strength and weaknesses. It concluded that local

health departments have come a long way in emergency preparedness since 2001, but that, at the time of the assessment, the average local health department was only "partially prepared."[35] The report suggested that the state public health department convene a workgroup of department leaders and representatives from local health departments and related organizations to develop plans and priorities in response to the report's findings. Officials from the state public health department and local jurisdictions have since met and implemented some of the report's recommendations. A summary of the recommendations and implementation status is appended to this report.

The Future of Public Health

This report is largely a progress assessment on the changes that have been made to the public health system in California since the Commission began its reviews in 2001. In assessing the state's progress, the Commission has found that more needs to be done to move public health forward into the future.

In the following chapters, the Commission reviews the challenges that continue to plague the state's public health system: leadership and organizational structure, public health infrastructure and funding mechanisms. Each of these areas is explored, with an emphasis on what can be done to improve public health in California as this new department establishes itself.

Leadership and Organization

Despite efforts to restructure California's public health system in the last few years, the state's leadership and organizational structure lack the authority and independence needed to fulfill its critical public safety role and guide statewide public health policy and act as a strong public advocate on behalf of Californians.

The Commission's previous recommendations to improve the state's public health system focused on both the strength of public health leaders as well as the structure of state public health programs. The Commission was concerned that: 1) The task of administering the Medi-Cal program dominated the consolidated Department of Health Services; 2) public health functions were distributed across several departments; 3) the existing structure undermined the state's ability to provide authority, coordination, planning and oversight; and, 4) the department was unable to effectively partner with local health officials, other agencies, universities, biotechnology, laboratories and the private sector.

To address these concerns, the Commission recommended a new organizational structure, more powerful leadership and enhanced involvement from scientific experts in the public health arena. Specifically, the Commission said the state should create an independent public health department led by a high-ranking state surgeon general and an authoritative public health advisory board.

The Legislature responded with the Public Health Act of 2006, which incorporated some, but not all of the Commission's suggestions. While the Public Health Act was a significant step toward addressing the challenges identified by the Commission, it falls short of establishing the authoritative leadership that public health experts and working public health professionals told the Commission was lacking.

Public Health Act Differs From Commission Recommendations

Problem	*Commission Recommended*	*Public Health Act of 2006 Created*
Organizational Structure	An independent Department of Public Health, separate from health insurance programs, that is positioned directly beneath the governor.	A California Department of Public Health, separate from health insurance programs, but under the umbrella of the Health and Human Services Agency.
Leadership	A California surgeon general who reports directly to the governor. The surgeon general should be a licensed physician selected by the governor from a pool of nominees recommended by a public health board and the California Conference of Local Health Officers based on scientific, medical, public health, leadership and management criteria.	A state public health officer, appointed by and serving at the pleasure of the governor, subject to confirmation by the Senate. The public health officer reports to the secretary of the Health and Human Services Agency and must be a licensed physician and surgeon with demonstrated medical, public health and management experience. Two chief deputies of the public health department also are appointed by and serve at the pleasure of the governor.
Scientific Expertise	A part-time, volunteer and scientific public health advisory board to provide expert involvement in the development of policies, regulations, and programs administered by the department or directly affecting the health of Californians. The board should: ▪ Consist of members appointed to fixed terms and imbued with a fiduciary responsibility to represent the public interest and protect the public's health. ▪ Be given independent professional staff through reassigning existing resources. ▪ Provide authoritative oversight of public health programs and regulations to improve effectiveness, examine ways to better use existing resources, analyze cost-effective alternatives for improving the health and safety of Californians and comment on regulations that will affect the public health. ▪ Encourage participation of related state and local government agencies, foundations and public health and other professional associations. ▪ Report at least annually to the governor and the Legislature on the priorities for government actions to improve the public health and on ways resources could be used more effectively. ▪ Systematically assess opportunities to consolidate or coordinate the work of other state health-related advisory boards, such as the Health Policy and Data Advisory Committee of the Office of Statewide Health Planning and Development (OSHPD). ▪ Ensure the state develops effective partnerships to tap the expertise of California's universities, academic medical centers, community clinics, foundations, private medicine, biotechnology and other high technology sectors.	A volunteer public health advisory committee that meets twice annually to provide expert advice and make recommendations to the public health officer on the development of policies and programs that seek to prevent illness and promote the public's health. The committee: ▪ Consists of 15 members, nine of whom are appointed by the governor, three by the Assembly Speaker, and three by the Senate Rules Committee. ▪ Serves under the direction of the state public health officer, who chairs the committee and has no administrative authority or responsibility. ▪ Will identify strategies to improve public health program effectiveness, identify emerging public health issues and make recommendations on programs and policies to improve the health and safety of Californians. ▪ Includes representatives from a broad cross-section of public health-related entities, including academia, biotechnology, business, community based organizations, emergency services, local government, health departments, medicine, nursing, public health laboratories, social marketing, consumers and other sectors of the public health community. ▪ Will sunset on June 30, 2011.

Department Leadership and Independence

In the year following the separation from health care services, the California Department of Public Health experienced major organizational change. Local health officers and emergency preparedness staff report that the department's removal from the health services department has brought renewed and much-needed attention to public health in California and that professional leadership is emerging within the department.[36] Mary Pittman of the Public Health Institute said that the new department has "raised the profile of public health" in California and "provided a foundation that will allow us to prepare and respond to future public health threats and opportunities."[37]

The journey has only just begun, and the department and state policy-makers must ensure the department continues to evolve. No reorganization unfolds smoothly: the creation of Department of Public Health was no exception and faced the added challenge of emerging as the state's fiscal condition deteriorated. It is still hobbled by leadership problems that the reorganization did not resolve. Local health officers say that core functions of public health have been significantly impaired during the department's first year.[38] The coming year will determine whether or not this is the result of start-up flux or something else that must be remedied in order for the department to move forward.

In its first year of independence, the new public health department took on a monumental task: dividing responsibilities that overlapped with health care programs, mapping its reorganization, making decisions about programmatic divisions, physically transferring staff and programs to another location, hiring new employees and configuring its new office space to meet its needs – all within its existing budget.

The enabling legislation called for the separation to be cost-neutral, yet the transition was not cost-free. The public health department spent $1 million on transition costs as well as $180,000 for a leadership consultant.[39] These should be one-time costs, and their impact should diminish going forward. Public health professionals outside the department, however, said that in the short run, the one-time costs hindered the new department's ability to continue normal operations as it restructured, as human and financial resources were diverted from other public health programs and spent on physically moving people and equipment, constructing new office space and reorganizing the management structure.

The department took several months to fill key positions, which also consumed resources and attention from public health work at the state

and county levels. According to the head of the County Health Executives Association of California, the "lack of continuity from staff turnover in senior management positions has created challenges for local health departments in establishing necessary working relationships."[40] This slowed the core business of the department as "the emphasis in structuring a new department with many new staff is focused on how to establish management and oversight functions," the CHEAC president wrote in testimony to the Commission.[41]

Separately, a reduction in General Fund contributions to the new department have cut into the new department's public health programs, leading the California Public Health Association (North and South) to express concern that in the current public health environment, the new department's capacity to respond to California's public health challenges has been diminished as a result of the split. It is not clear at this point what the lasting impact the General Fund reductions will be, given their small, if shrinking, portion of the department's overall budget.

The number of prevention services permanent staff has declined more than 18 percent over the past 10 years, and the capacity of the remaining workforce is in jeopardy as many on the department's staff approach retirement. The department has turned to temporary and contract employees for some of the vacancies and has eliminated training programs needed to train the next generation of managers and leaders.[42]

While these challenges contributed to the public health department's difficult beginning, witnesses indicated their concern that leadership problems may inhibit the department's ability to move forward in its new form.

Public Health Leadership Not Independent

The Commission previously expressed concern that public health leadership was politically, not professionally, based, and that the state health officer's power was limited by the position of the public health program within the agency and department structure.

California still lacks the independent voice the Commission concluded was needed in a department that protects the public's health and safety. Leadership remains politically-focused and under the control of an umbrella agency. Though the reorganization elevated the director by one level – he now reports directly to the Health and Human Services Agency secretary – policy positions, media responses and other important decisions by the state health officer or his executives still must be approved by leaders within the Health and Human Services Agency in addition to the Governor's office.

When asked about the department's approach to taking positions on health-related legislation, the state public health officer told the Commission that the ultimate policy of the governor's administration will dictate how the public health department will come out with a position on a measure.[43] This is a political response, not one of an independent health officer, as envisioned by the Commission in its previous recommendations. The Commission believes that Californians' public health and safety can be best served by a public health officer at the head of the department who is an independent advocate for the public.

While the current chain-of-command is common in many state departments, it is of heightened concern in the public health arena, where human life is at stake. The state's public health officer must be in a position to speak out on issues, even when controversial. Witnesses told the Commission that the public health department response on the issue of health care associated infections illustrates how the department's lack of independence can influence policy when it comes to protecting the health of Californians. Health care associated infections can be reduced significantly through prevention strategies, yet California has lagged behind other states in adopting measures to combat them. Bills were introduced in 2007 and 2008 to change the landscape of rules regarding health care associated infections in California. The department's experts, however, did not participate in the legislative process.[44]

This is an area in which the department has considerable expertise, yet it has been the Legislature that has taken the lead in pushing for stronger measures for reducing health care associated infections. Though the department has responded to legislation with the creation of an HAI advisory panel, it has reacted to legislative action rather than taken the initiative to drive change in this area. The department has said that it is relying on the panel's recommendations, which were reached through consensus, a slow-moving process, too slow, according to the panel's then sole non-industry representative. The Commission recognizes that implementing new procedures at financially-pressed hospitals can be difficult and entail added work for hospital staff and the benefits in savings and improved health outcomes is not immediate. This only underscores the importance for the state's health officer to take a strong leadership and education role in helping hospitals appreciate the long-term gains possible through this change. With the passage of recent legislation, SB 1058 (Alquist) and SB 158 (Florez), the department has taken up this role.

Health Care Associated Infections

Health care associated infections (HAIs) are medical conditions acquired by patients while being treated for other health problems in a health care setting. According to the Centers for Disease Control (CDC), HAIs are among the top 10 leading causes of death in the United States. The California Department of Public Health reports that approximately 240,000 California hospital patients each year develop hospital-borne infections, at an estimated cost of $3.1 billion per year, and that a significant percentage of these cases can be eliminated through increased surveillance and prevention.

In 2003, the Commission cited CDC's demonstration that practical interventions can eradicate antibiotic-resistant infections in health care settings. The Commission recommended action at that time. After nothing had been done by 2005, the Commission again urged the governor and Legislature to develop an aggressive response to these types of infections. Specifically, the Commission recommended that, by December, 2005, the administration should propose a plan to reduce the illness and death resulting from these infections.

In response to the Commission's recommendations, the California Department of Health Services, before it split into the new California Department of Public Health and the Department of Health Care Services, convened the HAI advisory working group in July 2005. By December 2005, the HAI advisory working group released a series of evidence-based recommendations to reduce the morbidity and mortality from HAIs in California.

After an unsuccessful 2004 attempt to require hospitals to publicly report infectious disease rates in hospitals, Senator Jackie Speier used the HAI advisory working group's recommendations as a foundation for SB 739 in 2006, which passed. The law, which went into effect January 1, 2008, established the Hospital Infectious Disease Control Program and created a statutorily required advisory committee to make recommendations on the prevention of HAIs. The new law did not require public reporting of infection rates. Instead, it required each general acute care hospital in California to evaluate and report on its implementation of HAI surveillance and prevention measures, and to implement specific measures to prevent the spread of certain HAIs.

As required by SB 739, the new public health department convened the health care-associated infection advisory committee to make recommendations to the department on the prevention of health care-associated infections. The law required the committee to include "department staff, local health department officials, health care infection control professionals, hospital administration professionals, health care providers, health care consumers, physicians with expertise in infectious disease and hospital epidemiology, and integrated health care systems experts or representatives." The state public health officer originally appointed more than 35 members to the committee, though only one member was a consumer representative. In October 2008, the department yielded to repeated requests made by consumer representatives to increase their representation on the committee, adding one more member to speak on behalf of consumers.

More recently, consumer advocates championed two bills to significantly advance the state's response to HAIs. The Medical Facility Infection Control and Prevention Act, SB 1058 (Alquist), requires screening, public disclosure and reporting of HAIs to the public health department, as well as other preventive measures by hospitals to combat health care associated infections. SB 158 (Florez) requires the public health department to establish a health care associated infection surveillance, prevention and control program, funded by hospital fees. Both bills were signed by the governor on September 25, 2008.

More Communication Needed to Leverage Expertise

Coordination and communication among state and local public health agencies and their partners is essential to a strong public health network, the Commission found in 2003. Policy-makers are part of this network and must be educated on public health needs and issues in order to make informed legislative choices that affect public health.

Department employees, legislative staff, and local health officers describe a department culture in which communication is limited, restricting the free flow of information to policy-makers, the media, and the public. As a general rule, it is not uncommon for employees in any department to be expected to "go through channels" before making any statements that could be taken as policy, yet the business of governing and developing legislation has long relied on informal exchanges of information to provide guidance and context to outsiders, a practice not encouraged at the department.

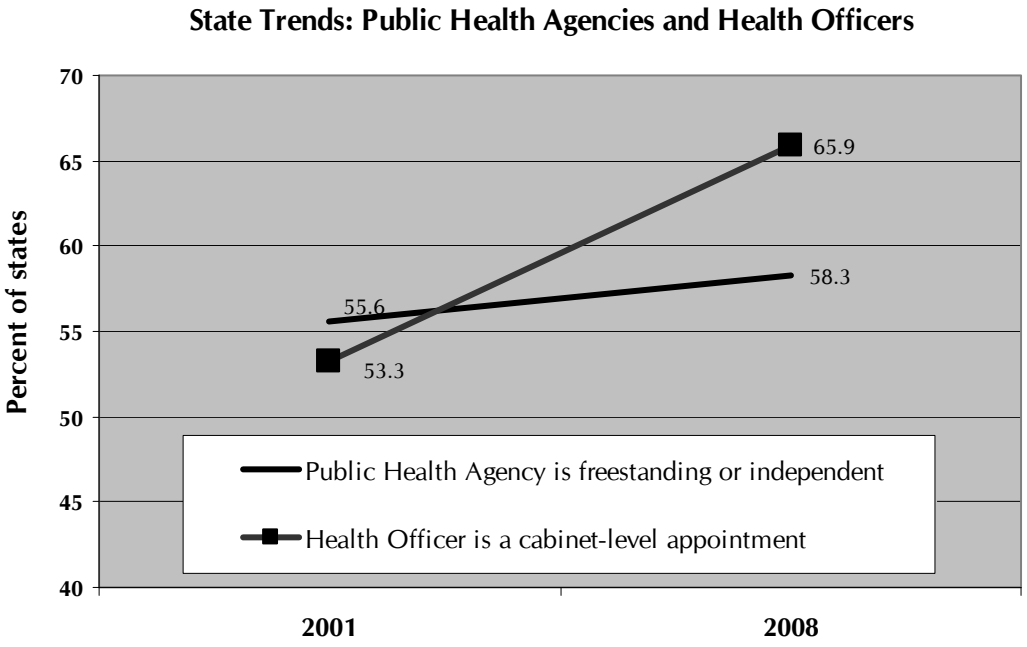
"It has been frustrating for the local health officers who work with the Legislature not to have our state physician colleagues at the table" in policy discussions with legislators," Ann Lindsay, president of the California Conference of Local Health Officers, told the Commission. Department professionals have valuable expertise that could assist decision-makers to ensure that the Legislature and governor are setting policies for the good of the state's public health. The lack of access to these experts, Lindsay said, results in "public health policy potentially being established by politicians without adequate scientific input."

In response to the local health officers' concern that public health department staff is not free to communicate with legislators, the state public health officer said that all department staff input on legislation is funneled through the department's legislative office in order to maintain consistency in the department's communications with the Legislature.

State Surgeon General

Local health officers said "the risk of limiting subject matter expert's availability of task forces and at hearings may be inherent since public health is not a cabinet level department."[45] These officers and many other public health stakeholders originally hoped the department, with a cabinet level state surgeon general at its helm, would report directly to the governor's office. Such a level of authority would allow the director to have the power to use the position of the office to advocate for public health policy for the good of Californians.

The Commission recommended that the state public health department be led by a California surgeon general who should report directly to the governor, following the same reporting structure as the California Emergency Management Agency. Given the stature of public health as a component of the state's public safety capacity and the challenges that the director currently faces because of its place within another agency, the governor and Legislature would benefit from an independent public health department located directly beneath the governor, with a state surgeon general in charge.



Trends show other states moving in this direction since 2001. Between 2001 and 2008, the number of freestanding public health agencies in all states grew slightly, from 55.6 percent to 58.3 percent and the prevalence of public health programs as a component of a superagency have accordingly declined. Increasingly, state health officers are becoming cabinet-level appointees, with more than two-thirds of the states recently reporting that the public health officer is a member of the governor's cabinet.[46]

Reestablish Public Health Board

In addition to an independent state surgeon general, the Commission previously recommended a part-time, volunteer and scientific public health board to provide authoritative expert involvement in the development of policies, regulations and programs administered by the

department or directly affecting the health of Californians. The public health board, the Commission said, was needed because the state lacked a public process, expert involvement and a venue for discussing health issues and linking public health functions and assets.

In its 2003 study, the Commission heard from health professionals who said that a public health board existed from 1870 to 1970. During that time, the board's monthly meetings provided a public forum for discussions about substantive public health issues, where public health experts exposed problems and established priorities for the state. Witnesses said the quality of public health programs declined after the prior state board of health ceased to exist in 1970.

The Commission's earlier study also noted that California's decentralized public health system consists of an extensive network of federal, state and local agencies and that most public health services are provided locally. The Commission found that a robust public health system must begin with a focused state effort, which then reaches out to these other partners. This theme was recently echoed by local health professionals who said that the state still needs to define the roles and responsibilities of each partner in the public health network.[47]

Many of the people leading state and local public health operations came of age professionally during a period of far greater state support for public health education, training and local departments. Since then, California has experienced profound changes in the way public health activities are funded and delivered. But California also has benefitted from advances in medicine, health technology and communications technology that allow health threats to be identified and addressed far more quickly than ever before.

Given the limits of public resources together with advances in the way public health is provided, state and local public health leaders need to build toward a public health system, one defined, as one advisory committee member said, not by "what it used to be, but what it has to be." [48]

A strong public health board envisioned by the Commission in 2003 could take the lead in defining roles and building partnerships that would strengthen the public health network.

Public Health Advisory Committee Limited in Scope

The Public Health Act of 2006 created a public health advisory committee "to provide expert advice and make recommendations on the development of policies and programs that seek to prevent illness and

promote the public's health."[49] The Act empowered the public health officer with the authority to convene and chair the advisory committee, which is to meet at least twice a year.

Though the public health advisory committee is still in its infancy, its statutory role is substantially smaller than that of the advisory board recommended by the Little Hoover Commission in 2003 and reiterated in 2005. By statute, the advisory committee is limited to providing advice to the state public health officer and has no administrative authority or oversight responsibility.

The advisory committee is dependent upon and under the direct control of the public health officer and the administration. As chair of the committee, the public health officer sets the meeting agenda, schedule and location; he chooses the issues to be discussed and determines whether to allow the committee access to department staff and information. Public health association representatives told the Commission they were concerned that "naming the state health officer chair of this committee will tend to deprive the incumbent, current and future, of the benefit of the best scientific information and professional judgment."[50] Others, including members of the Commission's advisory committee, agreed. Los Angeles County Public Health Officer Jonathan Fielding said that public health should not be politicized by limiting the power of this expert panel to merely an advisory role. Rather, the committee should have the enhanced authority of a board of health, Fielding said.

Committee membership is dominated by nine gubernatorial appointees; three of the 15 members are appointed by the Senate Rules Committee, and three by the Speaker of the Assembly. Members receive no compensation and are not reimbursed for travel expenses, which makes it difficult for some to attend the biannual committee meetings. Witnesses and members of the advisory committee said that the committee should meet more than twice a year if it is to be an effective tool for the department.[51]

The advisory committee also is hampered by a sunset provision that will automatically terminate the committee on June 30, 2011, though the public health officer has the authority to continue to convene the committee.

The limited role of the advisory committee is set by statute and is not attributable to the members of the committee. Members represent a broad cross-section of public health stakeholders from local health departments, academic and research institutions, non-profit organizations, and spanning medicine, nursing and public health

professions. Many are leaders in their respective institutions and practices and have unique and valuable insight to offer the department and to the Legislature.

Public Health Board Should Play Assertive Role

The public health advisory committee should be strengthened significantly and have an independent voice, separate from the control of the administration and the department, to champion health and safety causes in the face of potential political pressure. A stronger, more independent board could provide the state with policy guidance based on scientific, not political, analysis. Such a board also would give policy-makers access to public health experts, as members of the board would have greater authority and freedom to frame the discussion and offer their expertise. The board would provide guidance and oversight to the public health officer. To be truly independent, it needs to be able to choose its own chair rather than answer to the public health officer.

Membership of a bolstered public health board would be evenly distributed with appointees from the Assembly, Senate and governor. Members should be appointed to fixed terms. The board would be equipped with the resources necessary to meet monthly and empowered to elect its own chair. Qualifications of board members should mirror those of the current membership of the existing public health advisory

2008-2010 Strategic Plan

During its first year, the California Department of Public Health developed a strategic plan that outlines the goals and objectives for the department for 2008 through 2010. The strategic plan was released in July, 2008. It identified five goals, each with specific measurable objectives that carry out the director's priority in transforming the department into a performance-based organization. The goals include:

1. Increase quality and years of healthy life, reduce disparities and promote health equity.
2. Prepare for, respond to and recover from emergency public health threats and emergencies.
3. Improve quality and availability of data to inform public health decision-making.
4. Promote quality of the workforce and workplace environment.
5. Improve effectiveness of business functions.

According to the president of the California Conference of Local Health Officers, the strategic plan was "a necessary and important step to improve administrative functioning, particularly in light of [the department's] role as the major contractor with local health departments to carry out public health functions."

But, the strategic plan is "administrative rather than programmatic, and does not address strategies for addressing emerging public health issues like health inequities, chronic diseases and global climate change," said the local health officers' representative. Others add that the plan seeks administrative data sets that offer nothing more than raw numbers and should instead provide guidance on the coordination and integration of systems to improve public health programs overall. What is needed, said Peter Abbot, former president of the California Public Health Association-North, is a vision for public health in California, for how to recover after years of deterioration and lack of leadership, and for how to move forward on major public health issues.

committee. The board's purpose should be to provide expert public health information to the department, the administration, the Legislature and the public. The goal must be to ensure the state has expert, science-based guidance by a group whose only interest is the public health of Californians.

The board could be an important conduit, for example, for analyzing and further developing the department's strategic plan and forming strong links between academic institutions, nonprofit sectors, local health departments and private organizations to implement the plan. It could provide both expertise and personal connections to local officials needed to lead the discussions about how to delineate roles and responsibilities of each partner in the public health system. This discussion is essential to maximizing the finite public health resources available to California at all levels of government.

These potentially valuable contributions currently are not being solicited from the existing public health advisory committee, nor is the committee presently designed for this more involved role. By redefining this group into a public health board with greater autonomy and responsibility, the governor and Legislature can facilitate a coordinated evolution of California's public health system.

Summary

In passing the Public Health Act, the Legislature said that "a new department will create the opportunity to build strong leadership, resulting in increased protection of the public health and safety for Californians."[52] A year into the public health department's independence, it has realized important accomplishments, including transitioning out from under another department, restructuring the organization of its programs, developing a strategic plan and moving forward on a few key projects to improve its processes and leadership development.

However, it has not yet achieved the results sought by the Commission in 2003 and 2005. California still lacks a strong public health presence. Leadership is politically, not professionally, based. The state health officer does not report directly to the governor. Policy-makers have limited access to the department's experts. And California's assets and experts are not being leveraged.

California still needs a clear vision of the scope and framework of public health and the roles of the state public health department, local health departments, other government agencies, nonprofit organizations, private

entities, and individuals. It needs leadership that assesses state problems, provides guidance and facilitates coordination between public health partners, and strategizes on how to move forward into the future.

The solution is an autonomous public health board to provide this big picture assessment, vision and network, and a strong public health leader – a state surgeon general – who has the authority to take decisive action on matters of public health and the freedom to prioritize the health and safety of Californians above all else.

Recommendation 1: The governor and Legislature should make the California Department of Public Health an independent office, led by a state surgeon general reporting directly to the governor, to act as a forceful advocate for Californians on public health and public safety issues.

Recommendation 2: The governor and Legislature should transform the public health advisory committee into a state Board of Public Health to provide independent advice and guidance to the governor, the Legislature and the state public health officer.

- The governor and Legislature should enact legislation to replace the existing temporary advisory committee with a permanent public health board with the following characteristics:
  - ✓ Members should consist of an equal number of appointees by the governor, leaders of each party in the Senate and leaders of each party in the Assembly.
  - ✓ The board should provide scientific expertise on the department's public health programs and projects and should examine ways to address problems and improve the health and safety of Californians.
  - ✓ The board should report at least annually in writing to the governor and Legislature on the priorities for government action to improve public health.
  - ✓ Appointments should be for fixed, voluntary terms and members charged with the responsibility to represent the public interest and protect the public's health.
  - ✓ The state public health officer should be a member of the committee and should report to the board on a regular basis about the department's activities, regulatory projects, strategic planning progress, special projects, workforce needs and any other similarly critical issues or projects of the public health department.
  - ✓ The board should develop partnerships with California's academic institutions, foundations, and private medical, biotechnology and information technology industries.

- ✓ The board should meet monthly.

- ❑ Until a new advisory committee is created, the state public health officer should bolster the stature of the existing advisory committee by:
  - ✓ Convening advisory committee meetings at least quarterly.
  - ✓ Allowing committee members to develop the committee's agenda and priorities.
  - ✓ Devoting resources to reimburse committee members for meeting-related expenses.
  - ✓ Directing the committee to develop an annual report for the governor and Legislature identifying priority areas where state action is needed to improve public health in California.

Public Health Infrastructure

Even with the right leadership structure, public health is only as good as those who do public health work, and only then if they have the tools necessary to do the job. The public health infrastructure is a "complex network of people, systems, and organizations working in the public and private arenas" – basically any part within the public health system that helps health professionals protect public health and public safety.[53]

The Commission previously recommended that California significantly strengthen its public health infrastructure, especially its expert and technical workforce and its technological abilities and assets – such as real-time surveillance systems – to counter emerging public heath threats.[54] Witnesses in 2003 told the Commission that California needed to substantially improve and modernize its laboratory diagnostics and disease reporting capacity, and that the state needed to invest in human capital as part of a long-term strategy.[55] The state lacked the public health staff, tools and technology, laboratory capacity and emergency response capabilities to adequately protect the health and safety of Californians.

California's public health workforce and laboratory capacity remain in need of significant attention. Qualified public health professionals are in high demand both in California and nationally, and the state's difficulty hiring these workers is compounded by salaries that are lower than those in the private and even local public health departments. The inability to fill positions, coupled with repeated state budget cuts, has resulted in the state laboratory closing down one of its units, eliminating the state's ability to provide more than two dozen laboratory tests previously conducted at the state level.[56] This raises concern, but it also begs the questions of who should provide which services and whether the current system reflects the best choice of today's options compared to what was available when the present structure was established. Answering these questions is a task that would be well-suited for an independent public health board.

> ***"California's public health system can only be as strong as its public health workforce."***
>
> Mary Pittman, President and CEO, Public Health Institute.

Because of the current condition of the state's public health infrastructure, public health lab professionals expressed the fear that California's public health system is at risk of failing to provide the most basic services that ensure the public is protected from health threats.

Public Health Workforce

A key challenge facing the new California Department of Public Health as it moves forward is the state of its workforce. In 2003, the Commission identified as a major problem the state's inability to attract and maintain a robust team of public health experts and recommended that the state take action to address this deficiency.

According to interviews in 2008 with department staff and local public health officials, California's efforts to bolster its public health workforce have not been sufficient.[57] The public health department experienced significant turnover during and immediately following its split from health care services and took several months to fill key positions, such as the center directors.[58] While turnover may be inherent in a transition that involves separating from another department, the flux compounded the related problem of pre-existing vacancies within the department, which resulted in a decline in morale. Employees also report that the creation of the new centers of operations, each with its own director, has added another layer of administration to the department's chain-of-command, contrary to the state public health officer's intent to flatten the organizational structure.[59]

California Department of Public Health
Vacant Positions by Program Area
December 1, 2007

Division	Vacant Positions	Authorized FTE Positions	Vacancy Rate
Administration Division	24	245	10%
Center for Chronic Disease Prevention & Health Promotion	22.55	195.50	12%
Center for Environmental Health	74	650	11%
Center for Family Health	53.10	453.95	12%
Center for Health Care Quality	208.50	1009.75	21%
Center for Infectious Disease	56	290.10	19%
Executive Division	14	59	24%
External Affairs	3	11	27%
Health Information and Strategic Planning Division	38	255.25	15%
Information Technology and Services Division	13	68.75	19%
Internal Audits	0	7	0%
Office of Legal Services	16	46	35%
Public Health Emergency Preparedness	22.30	59.30	38%

Source: California Department of Public Health. April 2, 2008. "Vacancy Report – Budget Item 4265-001-0001." Rates are rounded to the nearest whole number.

The Legislature, sharing the Commission's concern about the status of the state's public health workforce, asked the public health department to provide an annual vacancy report to the Legislature beginning on December 1, 2007. The first report, submitted in April 2008, showed that the department had 3,350.60 authorized positions, 540 of them vacant, producing a total vacancy rate of 16 percent, compared to an overall state average vacancy rate of 12 percent.[60]

The State Personnel Board estimates that 35 percent of the state's workforce (70,000 employees) will be eligible to retire in the next five years, and 44 percent of the state's current workforce is 45 or older, a dynamic shared by the Department of Public Health as well.[61] Though the recent economic downturn may delay some of the retirements by this wave of eligible baby boomers, any large scale exodus will exacerbate the state government's need for more workers, public health and otherwise.

A comprehensive assessment of public health department employment data since 2005 is difficult, given the restructuring of public health programs after the separation of the two departments which complicates direct comparisons. Many positions were in programs spread across departments that have been significantly altered. Comparing the number of staff in a few specific divisions from 2005 through 2008 gives some indication of the department's experience in each of these programs. The table below shows that while some divisions experienced gains in the number of staff employed since 2005, some divisions continued to lose staff, compounding substantial declines between 2001 and 2005. The largest decline has been in critical laboratory science positions, where staff currently is half the size it was in 2001.

Public Health Staffing Levels by Division

Division	2001-02 Positions	2005-06 Positions	Percent Change from 2001-2005	2008-09 Positions	Percent Change from 2005-2008
Environmental & Occupational Disease Control	85.4	66.5	-22%	66.5	0%
Communicable Disease Control	118.5	129.5	9%	116.5	-10%
Drinking Water & Environmental Management	183	175	-4%	208	19%
Food, Drug & Radiation Safety	135.5	105	-22%	123	17%
Health Information & Strategic Planning	45	36	-20%	31	-14%
Laboratory Science	83.5	65	-22%	44.5	-32%
Licensing & Certification	388.5	345.5	-11%	375.3	9%

Source: California Department of Health Services. May 25, 2005. Written testimony submitted to the Commission. Also, José Ortiz. Administration Chief. California Department of Public Health. November 6, 2008. Personal communication.

Nationally, health leaders are concerned that the public health workforce as a whole does not have enough people to meet current needs, with shortages particularly acute in positions that require specialized training. A national study reported that local public health departments across the nation are having difficulty finding epidemiologists, health educators, microbiologists, environmental scientists, dieticians, nutritionists, laboratory directors and public health aids.[62] State and local health officials in California echoed the difficulty in finding public health workers with the necessary credentials and experience, especially microbiologists and laboratory director positions.[63]

Public Health Microbiologists

Public health microbiologists are the foundation of state and local laboratories and attracting and keeping more of them in state service has been deemed "workforce challenge No.1" by the state public health officer.[64] The table on the following page shows vacancy rates for microbiologists in the state's two laboratory branches that employ the largest number of microbiologists – the Viral and Rickettsial Disease Laboratory and the Microbial Disease Laboratory.

Laboratory Science Staff Vacancies

The vacancy rate as of December 1, 2007 for laboratory staff is slightly higher, at 19 percent, than for the rest of the public health department. A breakdown shows the vacancy rate by laboratory branch.

California Department of Public Health Laboratory Personnel Vacancy Rate by Division	
Office of the State Public Health Labs - Richmond	22%
Microbial Disease Laboratory	23%
Viral and Rickettsial Disease Laboratory	15%
Environmental Health Laboratory	33%
Food and Drug Laboratory	21%
Sanitation and Radiation Laboratory	3%
Genetic Disease Division	12%
Environmental Laboratory Accreditation	28%
Laboratory Field Services	14%

Source: California Department of Public Health. April 2, 2008. "Vacancy Report – Budget Item 4265-001-0001." Rates are rounded to the nearest whole number.

Public Health Microbiologist Vacancy Rates

	Viral and Rickettsial Disease Laboratory			Microbial Disease Laboratory		
Year	Number of PHM vacancies	Total PHM positions	Vacancy rate	Number of PHM vacancies	Total PHM positions	Vacancy rate
2002	3	27	11%	2	35.5	6%
2003	5	27	19%	6	43.5	14%
2004	4	26	15%	5	41	12%
2005	2	25	8%	6.5	36	18%
2006	9	30	30%	13	41	32%
2007	7	31.5	22%	7	38	18%

Source: Ann Lindsay. President. California Conference of Local Health Officers. August 28, 2008. Written testimony to the Little Hoover Commission.

The microbiologist position requires specific qualifications unique to the government laboratory system. The classification series requires an undergraduate college degree in a biological science-related major with specific science courses, a 26-week training program followed by a state exam, resulting in a public health microbiologist certificate issued by the public health department. This certificate allows public health microbiologists to work in a state or county public health laboratory in addition to a private clinical laboratory.[65]

Once certified, a public health microbiologist also is eligible to work for a private clinical or commercial laboratory. The reverse, however, is not true. A microbiologist who began working in a clinical or commercial setting and received a clinical laboratory services certification would not meet the requirements for work in a public health laboratory without additional training and testing.[66] As a result, microbiologists can leave the state for a private laboratory, but privately-employed microbiologists cannot easily enter the public health laboratory system.

Even if a privately employed microbiologist could easily enter the state system, they likely would face a lower pay scale. State microbiologist salaries lag behind those in the private sector by roughly 30 percent.[67] With so many vacancies in these state positions and repeated cuts to laboratory programs, those who remain in these positions take on an increased workload.[68] This combination of factors creates a difficult recruitment environment for the state.

In recognition of the pay disparity, state public health microbiologists have recently received some salary increases. In 2006, the California Association of Professional Scientists, Unit 10, negotiated a two-step increase amounting to a salary gain of 10 percent. Microbiologists also received a 3.5 percent cost of living increase in July 2006 and another

Monthly Salaries for Public Health Microbiologist Positions in County Labs Near the Richmond Lab	
Alameda	4,948 – 5,874
Contra Costa	4,747 – 5,489
Marin	4,656 – 5,585
San Mateo	5,422 – 6,777
San Francisco	5,701 – 6,932
Santa Clara	5,938 – 7,932
Average Bay Area salary	**5,235 – 6,432**
State PHM I salary	**4,153 – 5,372**

Source: "Salary Survey 2007/2008." California Association of Public Health Laboratory Directors.

3.4 percent increase in July 2007, along with the rest of the state workforce.[69]

These increases have not allowed state microbiologist salaries to catch up to comparable county positions or private sector lab positions. The annual state salary for a state public health microbiologist ranges from $49,836 to $64,464. The average annual salary for a public health microbiologist level 1 at a local public health laboratory in the San Francisco Bay Area surrounding Richmond, where the state laboratory is located, is $62,820 to $77,184.

Public health microbiologists with the state have enjoyed heightened job security, employment benefits and the potential for a pension, though such considerations have not made up for significantly higher salaries at private companies or even at county health labs, which offer higher salaries as well as job security and benefits similar to the state. The salary disparity puts the state laboratory at a disadvantage to other laboratories, private and public.

Local Public Health Laboratory Directors

While local public health labs are better able to attract microbiologists, they have experienced a shortage of local public health laboratory directors. Without a qualified laboratory director overseeing laboratory operations, a county cannot run an accredited public health laboratory.

Approximately a third of California's county public health laboratories currently lack a full-time laboratory director. Some counties make do with retired directors working part-time; other counties share laboratory directors who work in multiple labs, as is the case with Fresno and Merced, Humboldt and Sonoma, and Napa and Solano counties. Of the 39 existing county public health laboratories, 33 have directors who have retired or who are eligible to retire.[70]

County public health officers and county lab directors told the Commission that the shortage of laboratory directors is the result of lower salaries offered to public health laboratory directors than to private lab directors, as well as the shallow pool of candidates able to meet federal and state requirements for the laboratory director position.

Federal law requires each state and local laboratory to operate under the direction of a laboratory director who holds specific credentials, including a doctoral degree and post-doctoral experience.[71] California requires laboratory directors to possess a bachelor's degree, as well as a microbiology certification issued by the state and four years of experience. To be hired today, a laboratory director in California must meet all of these state and federal requirements, though the number of people – lab directors or potential lab directors – who actually have met both the state and federal qualifications is quite low, witnesses told the Commission.

County Public Health Laboratory Directors

In 2001, all of California's 40 public health laboratories were directed by full-time directors. As of January 2008, one-third of California public health lab directors serve only on a part-time basis. Two counties, Solano and Napa, merged into a single lab and therefore share a director. Over half of the directors (22) have retired since 2001 and only nine of those positions have been filled on a full-time basis. Here is a breakdown of the employment and retirement status of current lab directors for the now 39 local laboratories in California:

- 27 labs have a full-time director; 22 of these are eligible to retire.
- 12 labs have a part-time director; 7 of these are retired and 4 are eligible to retire.
- 10 lab directors currently have a Ph.D. or Dr.P.H.; all 10 are retired (2) or eligible to retire (8)

Source: "2008 Status of California Public Health Laboratory Directorships." California Association of Public Health Laboratory Directors. January 18, 2008.

When the federal rules were adopted in 1988, many laboratory directors who did not have the required characteristics were allowed to remain in their director positions under a legislative "grandfather" clause that exempted them. This was designed to give the state time to prepare and develop candidates who could meet the stricter requisites. California failed to prepare adequately for the wave of retirements of these exempted directors, who met state requirements, but who are now departing from local laboratories, leaving vacancies that can be filled only by new directors who meet the far-stricter requirements.

To address this need, the California Association of Public Health Laboratory Directors is seeking to exempt California public health labs from the federal requirements. The association enlisted the assistance of Congresswoman Doris Matsui on federal legislation to allow California laboratory directors to meet only the state's requirements, eliminating the need for a doctoral degree and postdoctoral work. Although the state public health department has taken no position on the federal legislation, the state public health officer expressed concern to the Commission about weakening the required credentials for California's local laboratory directors.[72]

Department Efforts

Public health leaders have been aware of the changes in federal rules for laboratory directors, yet in the span of 18 years after the federal law

passed, the state has been slow to respond adequately to the new requirements. The Commission also warned of workforce deficiencies in 2003 and again in 2005. It was not until 2006 that public health leaders took action to address the shortage of microbiologists and laboratory directors.

LabAspire. The public health department began to collaborate with UC Davis, UC Berkeley, UCLA and the California Association of Public Health Laboratory Directors in 2006 on an outreach and training program called LabAspire. The program provides laboratory placement and training for two post-doctoral fellows each year in order to prepare them for a public health laboratory director assignment. LabAspire received $2.5 million annually for years 2006-07 and 2007-08. Funding for the program was reduced to $2.25 million for 2008-09.

The department's collaboration with academic institutions to develop LabAspire to address the shortage of laboratory professionals is noteworthy and provides an example of the leadership needed from the public health department going forward in this and other areas of public health. The department can continue to provide this valuable leadership role by analyzing the results of LabAspire and refining the program to ensure that the outcomes justify the investment. While the program has outfitted some local health jurisdictions with training equipment that allowed them to continue to provide microbiologist training, LabAspire has not yet produced more public health laboratory directors. The program's first two Ph.D. candidates graduated in 2008, but each left California's public health laboratory system upon graduation. One went to work for the national Centers for Disease Control, the other went to work for UCLA. Seven candidates currently are participating in the program, of whom five are expected to graduate in 2009.[73] If the program continues to produce the results it achieved in 2008, the state will not meet the projected need for laboratory directors in the coming years.

The department should consider ways to increase the number of participants while also ensuring that candidates who receive financial support stay within the public health laboratory system. For example, one of the institutions receiving grant money, UC Berkeley, has incorporated pay-back obligations so that, when a candidate finishes the program, the graduate must work in a public health laboratory for one year of service for each year of financial support received, or the money must be returned in the form of loan repayments.

Leadership and Workforce Development. Apart from LabAspire, the department has taken steps to strengthen its overall workforce through a new Leadership and Workforce Development project, which seeks to

create and train consistent leadership and a competent public health workforce "to meet the future demand for quality public health services in California."[74] The $227,000 contract was awarded in November 2008, and will move forward despite the governor's executive order suspending new contracts in response to the state's budget problems.[75]

By spring of 2009, the project will produce: 1) a plan to establish an Office of Leadership and Workforce Development; 2) an Annual Performance and Development Plan with tools, training and administration; and, 3) survey tools to assess recruitment effectiveness, retention issues, overall employee morale and satisfaction and workplace improvements that are recommended by employees. This is an important step for the department to assess and improve its desirability as an employer and make changes to attract and retain talented public health professionals. It also is an effort that would benefit from independent oversight and review of its performance, a role best performed by an independent expert public health board that meets regularly.

New Public Health Department Can Leverage Partners

While the department's efforts are a step in the right direction, the public health department could do more to address the public health workforce shortage within the department as well as across the state. The department, however, cannot do this alone. The broad agenda for public health in California, combined with a challenging split and significant budget reductions, makes it difficult for the department to address all of the state's public health needs on its own. A solution to the workforce problem will require a coordinated effort of multiple partners, including the community college system and California's two university systems, and, in the area of emergency services, the new California Emergency Management Agency.

This is a critical task for the public health officer, who must communicate a vision of what an integrated program should look like, then gather stakeholders and make the case to the governor and Legislature. This task should be shared with an independent and empowered public health board, the members of which should be tapped for their expertise and contacts. The advisory board has the potential to be a valuable asset, but that value will not be realized in its present limited role. Its members have a stake in ensuring the state has a strong public health workforce and should be empowered to help devise solutions.

Recommendations for a Robust Public Health Workforce

A Public Health Workforce study commissioned by the Health Resources and Services Administration of the U.S. Department of Health and Human Services issued nine recommendations for consideration by public policy makers at all levels of government to bolster the public health workforce:

1. Learn more about what attracts potential public health workers to the field and use this information to develop innovative recruitment and marketing strategies for careers in public health.
2. Provide more opportunities for public health training and education that are accessible to senior staff of district and local health offices, particularly those in leadership positions.
3. Provide public health workers with support and assistance to further their education related to critical public health skills and competencies. This could include tuition reimbursement, release time and increasing the availability of distance education or web-based course offerings.
4. Create a service-obligated scholarship or loan repayment program modeled after the National Health Service Corps that provides scholarship or loan repayment support in return for a commitment to work in local public health offices/agencies short on public health workers.
5. Identify and describe effective 'career ladders' within State public health systems that could assist other States in developing similar opportunities, particularly in shortage occupations.
6. Encourage schools of public health, public health training centers, and other educational programs to be more responsive to the recruitment and training needs of local public health agencies, particularly those in remote locations. Identify and describe models of collaboration or 'best practices' between academia and public health practice. Provide incentives to encourage collaboration between relevant educational programs and local public health agencies.
7. Support the development of a model public health curriculum that could help prepare public health professionals for contemporary public health practice and make the curriculum available to schools of public health, medicine, nursing and other health professions.
8. Provide dental public health training to more dentists and dental hygienists to work in local public health departments to run comprehensive preventive dental programs including fluoridation, screenings, sealants and oral health education and advocacy.
9. Monitor the size and composition of the public health workforce on a regular basis, with a focus on 'functional' enumeration, i.e., understanding the public health workforce within a State based on the roles and responsibilities of the public health system within the State.

Source: Health Resources and Services Administration. U.S. Department of Health and Human Services. "Public Health Workforce." January 2005.

The workforce issue is inextricably bound to the broader need for a forward looking assessment of the roles and responsibilities of each public health partner, public and private, to see where overlaps exist and can be eliminated the resources shifted to fill gaps in services. An independent and empowered board's members could and should play an important oversight role in evaluating the department's workforce development efforts.

Collaboration with Academic Institutions. A Public Health Workforce study commissioned by the Health Resources and Services Administration of the U.S. Department of Health and Human Services found that while the state and some local health departments in California had relationships with medical or nursing schools, not one of them had a similar relationship with a public health school. The 2005 study explained that all departments surveyed in California reported very little connection with schools of public health for workforce training or recruitment. The study found that "internship and clinical training opportunities were so limited within a public health setting that the next generation of [public health nurses] and physicians and dentists are not being mentored within the system."[76]

The public health department could form partnerships with academic institutions to monitor and develop the state and local public health workforce and ensure the pipeline is full of potential public health professionals, from entry-level workers to Ph.D.'s. The department has initiated partnerships in select cases such as for laboratory directors and microbiologists. Some educational institutions have reached out to local health departments to understand workforce needs and ensure that the appropriate education programs are in place to help students meet specific job requirements.

The California Community Colleges Health Care Initiative, for example, is a broad effort that provides education and training programs to meet emerging demands for health care delivery. The initiative includes eight Regional Health Occupations Resource Centers across the state to link education providers with the health care industry. The centers' activities differ according to local needs and may include job analyses, curricula development, training, certification testing, and employee referrals to health care industry employers.

In San Francisco, a Regional Health Occupations Resource Center director facilitated a partnership between the San

Connecting Health Care Workforce Development and Education

There are many potential partners who may contribute to the development of the state and local public health workforce.

In its 2007 report, *Career Technical Education: Creating Options for High School Success*, the Commission recommended that California must better align its education, workforce development and economic strategies. The Commission discussed ways to maximize connections between high school CTE classes and job and college opportunities, particularly in professions like health care, where there are critical shortages of workers in high-demand, high-wage jobs.

The Arthur A. Benjamin Health Professions High School in Sacramento, for example, is a small health career-themed high school that partners with the health care industry to provide work-based learning opportunities and student internships. The principal and vice principal coordinate with 300 health care business partners, setting up 250 intern placements, 35 field trips and 50 guest speakers each year.

Career-themed high schools that focus on the health professions provide an opportunity for state and local public health care workforce development leaders to reach out to students who already have an interest in health care and make them aware of career opportunities in public health.

Sources: Little Hoover Commission. Career Technical Education: Creating Options for High School Success. November 2007. Also Matt Perry, Principal, Arthur A. Benjamin Health Professions High School. Sacramento, CA. May 23, 2007. Site visit.

Francisco City College and the San Francisco Department of Public Health to create a certificate program at City College that would satisfy part of the requirements for the Community Health Worker job classification at the city's health department. As a result of the collaboration, students are equipped with the exact job qualifications needed to work in the county's program. Between 30 and 35 students graduate with the certificate each year and enter the public health workforce.

The state public health department now is in a position to make broader connections among these efforts and build partnerships with academic and other institutions to increase the number of graduates with specific public health requirements for positions in both the state and local public health departments.

Public Health Workforce Data. To better provide leadership for these partnerships, the state needs to better understand the nature and extent of California's public health workforce deficiencies. A national Public Health Workforce study suggests that states should monitor the size and composition of the public health workforce on a regular basis.[77] Currently no statewide data exists in California on public health professionals, students pursuing public health careers or those approaching retirement.

"Advocating for recruiting resources and training new generations of workers are based on understanding what is happening today. Workforce enumeration data can guide schools and universities in providing the skills students need. Such data can also improve marketing campaigns to attract new workers to public health. Knowing the true size and nature of the workforce is important for all aspects of workforce planning and development."
Association of State and Territorial Health Officials. 2005. "Strategies for Enumerating the Public Health Workforce." Page 8.

As previously mentioned, the governor and Legislature acknowledged this lack of data in the broader context of health professions by enacting SB 139 in 2007 to create the Health Care Workforce Clearinghouse. The clearinghouse will collect health workforce and education data in California, including supply, demand, geographical distribution and diversity of health workers by occupation and educational capacity.[78] California's Office of Statewide Health Planning and Development is in the process of setting up the specific details of the clearinghouse and has convened focus group sessions to identify users of the system and the data to be collected.[79]

Given the state's need for microbiologists and other laboratory personnel, for example, data should be collected for these particular health professions. Yet OSHPD staff working on the clearinghouse indicated that no one participating in the discussions has articulated a need for data on public health microbiologists, though the public health department has been represented at two of the three meetings.[80]

The public health department should advocate for the collection of specific data in the clearinghouse in order to monitor the state of its public health workforce. Without timely information about potential workforce deficiencies and the level at which the academic pipeline is

filled with potential candidates for these positions, the department cannot proactively address current or oncoming shortages.

Laboratory Capacity

The state public health laboratory system is a network that includes state and local public health laboratories, federal laboratories, other state agencies, private laboratories and other organizations and health care providers. These laboratories are vital to the state's public health system, serving as sentinels and investigators. Without timely test results, public health professionals cannot adequately respond to health threats as they emerge. The Commission previously expressed concern that laboratory capacity had deteriorated substantially over time and needed significant attention to ensure the state was properly equipped to deal with public health emergencies.

The Commission's concern has not diminished. California continues to be challenged with laboratory personnel recruitment and retention problems, as the public health department acknowledged in its laboratory capacity assessment in 2007 that identified workforce as a major laboratory capacity issue. The state also has made additional cuts to the state public health laboratory system that have reduced testing programs important to protecting public health.

Given continuing concerns about the threat of a biological attack, as well as the potential for outbreaks of avian and pandemic flu, a strong state laboratory is critical to the state's ability to identify and quickly respond to disease-based emergencies.

Reduced Public Capacity for Testing

According to the California Conference of Local Health Officers, the state has continued to lose the capacity to provide quick diagnostic services for counties and hospitals during outbreaks of influenza, measles, rabies, varicella/chicken pox, food borne illnesses, viral hepatitis, West Nile Virus and unexplained severe respiratory illnesses and deaths.

Recently, the state halted its rapid testing for multi-drug resistant tuberculosis, which means the state no longer delivers these results to counties within a few days – instead, local health departments must wait six weeks for the test results, CCLHO president Ann Lindsay told the Commission. This means that county health officials might treat patients with inappropriate medication, which exposes the patient to potential drug toxicity and may lead to a more resistant tuberculosis strain.[81] It also results in delayed treatment, which in turn increases the

chances that a patient with tuberculosis will infect others, as tuberculosis is contagious and spreads through the air.

In response to the Governor's request for 10 percent across-the-board budget reductions imposed on state agencies for fiscal year 2008-09, the department reduced funding in its Microbial Disease Laboratory as part of its overall budget adjustment. The department closed its immunoserology unit, which provided testing for over 32 diseases, including Lyme disease, malaria, plague, typhoid fever, syphilis and tularemia. These tests no longer are available through the state public health laboratory and must instead be submitted to the national Centers for Disease Control.[82] Local laboratory directors said that submitting these tests to the CDC extends the turnaround time for lab results by weeks or months, depending on the type of test.[83]

Lives depend on timely lab results. Malaria, for example, should be considered a potential medical emergency, according to the CDC, which says that "delay in diagnosis and treatment is a leading cause of death in malaria patients in the United States."[84] While health professionals can make a conditional call on a case of suspected malaria based on symptoms in a clinical setting, a definitive diagnosis depends on laboratory tests that confirm the presence of malaria parasites. Without timely tests, medical providers lack the information needed to make accurate diagnosis for patient treatment, and public health workers are delayed from taking preventive measures to reduce exposure to others that leads to an outbreak.

At this point, it is not clear whether or to what extent the closure of the state lab's immunoserology unit increases the state's vulnerability to communicable disease, though it does highlight the need to ensure that the work of the department's Tuberculosis Control Branch is effective. This is an area that will require focused Legislative oversight and underscores the need for an independent expert public health board that could evaluate the impact of such budget reductions.

Laboratory Capacity Assessment and Working Group

As discussed in the background chapter of this report, the state public health department conducted an assessment of the state public health laboratory capacity in 2007. Following that review, the department formed a public health laboratory system working group of state and local public health and laboratory stakeholders to continue to assess needs and make recommendations to the department.

The working group is an important effort by the department to consider alternative approaches to the shortage of lab directors. One approach

being discussed by the group is regionalizing public health laboratories. Under this concept, the two or more counties join together so that a single laboratory could serve multiple adjacent counties. This would allow the cooperating counties to leverage scarce resources and create economies of scale. It also would reduce the demand for laboratory directors as a laboratory director could manage a single lab that provides services to more than one county. Conversely, should a director of a regionalized lab leave or retire, more counties would be in danger of losing lab services.

The Commission recommended in 2003 that the state consider regionalizing its local laboratory services as a way to bolster capacity. While the department has been slow to begin the discussion, it has more recently played a leadership role in facilitating the laboratory capacity working group and suggesting that it could provide technical assistance to counties that show interest in merging laboratory operations.[85] However, the department's efforts have met resistance from many county laboratory directors who disagree with the state's suggestion of regionalizing county laboratories. The California Association of Public Health Laboratory Directors said that county public health laboratories already are regionalized, as 39 local laboratories serve the state's 61 local health departments. Further consolidation would cause delays in getting test results, the group said, as the counties would need to send their specimens to other counties for testing. This could further limit capacity of the laboratory system as well as diminish local labs' sentinel role, the laboratory directors association said, particularly in cases of bioterrorism, where 15 reference-level laboratories currently provide certain tests.[86]

Regionalization would result in fewer local laboratories throughout the state, but there is no evidence to suggest this will reduce the level of laboratory services provided across California. On the contrary, California has 39 local laboratories, far more than the next two largest states: Texas, which has 22 local public health laboratories, and New York, with only nine.[87] Even if 10 of the state's 39 local laboratories were each consolidated with another lab, the state still would have 29 local laboratories, almost double the number of California's 15 reference-level labs.

Existing county-level capacity already is threatened because of local jurisdictions' inability to hire and retain laboratory directors. A frank assessment is required to determine what impact this credential-based constraint has on the ability of counties to respond to demand for laboratory services, particularly during a surge situation. Counties that choose to regionalize lab services could experience cost savings, which could be redeployed for other public health needs.

Given the state's budget for public health and laboratory services, the department needs to consider new ways to ensure that all the necessary public health services can be provided in the most cost-effective manner that still produces quality and timely results. The state public health department, with the assistance of a stronger public health board, is in the best position to analyze need. Such an analysis should look beyond what has been done in the past to how the state can provide the most efficient laboratory services across the state and whether regionalization is part of the answer to serving the state's needs.

Counties considering whether to combine operations can benefit from the experience of adjacent Napa and Solano counties, which in 2000, united their county labs under one roof through a joint powers agreement.[88] The collaboration was in response to mutual problems that counties were having with budget shortages and difficulties in hiring laboratory personnel.[89] It has been successful enough that Napa and Solano counties renewed the joint powers agreement in 2005 and again in 2008. In addition, the combined lab provides testing services for Humboldt, Lake and Mendocino counties.

The Napa-Solano County Public Health Laboratory is located in Solano county and run by a single laboratory director. Employees are hired and paid by Solano County, while Napa County provides financial assistance to cover a portion of the costs to run the lab. The nature of the joint powers agreement allows more flexibility for the counties to maintain a collaborative relationship in administering the laboratory services, which differs from a model where services are provided by contract, although contracting is another option.[90] The Napa and Solano County public health officers said the joint laboratory works well and they plan to continue the agreement into the future.[91]

Beyond the Napa-Solano model, regionalization also has been practiced by laboratories statewide on a regular basis for specific levels of laboratory tests, as mentioned above.

When a local laboratory receives a potential biological agent that it cannot rule out as a threat, the laboratory forwards the sample to one of 15 CDC-designated Public Health Laboratory Response Network Reference Laboratories. These reference labs are organized into catchment areas, or regions, where the reference lab serves its neighboring counties. Through this system, laboratories have procedures for specimen transport and communication about test results from one laboratory to another.

This map was prepared using public domain data made available by the California Spatial Information Library (CaSIL). Website: http://gis.ca.gov

Private health providers also use public health laboratory services in a manner that is not location-specific. Local laboratories charge fees for services provided to these private companies, some of which are out-of-state and send their samples through the mail.

The current environment of limited funds and expanded expectations for public health provide an opportunity for the state public health department to take the lead to address specific challenges that public health professionals face. By facilitating the laboratory working group discussions about how to enhance laboratory capacity, the department has shown leadership in this area.

Summary

California's public health leaders have taken important steps forward to strengthen the state's public health workforce and laboratory capacity. However, the state missed critical opportunities to make progress in solving the acute workforce shortage in key areas that developed from inaction. Because of the extent of the department's personnel problem, far more work must be done to improve the department's ability to recruit and retain public health professionals. The Leadership and Workforce Development initiative is a significant step forward. It must move as quickly as is practical. The governor and Legislature should support this and other efforts to assess and improve staffing levels within the department and beyond.

"Achieving the vision and reaching the goals set forth by Healthy People 2010 will require the concerted and collaborative efforts of different components of society, whether it is the public sector, the private sector, state agencies, nongovernmental entities, learning institutions, or the community at large."

Institute of Medicine. 2003. "The Future of the Public's Health in the 21st Century." Page 31.

In order to make the major advances needed in California's public health system, the state must broaden its network to include all public health partners, not just those within state government. The public health department should use its place as the state's public health leader to partner with local, academic and private industries to initiate broad efforts to bolster the department's and the state's public health workforce.

Now that the department has begun to collect and report vacancy data to the Legislature annually, workforce deficiencies can be tracked over time. Moving forward, the vacancy report will provide the department with a useful tool for workforce planning and advocacy to the governor and Legislature for necessary personnel increases. The department should continue to stay abreast of the department workforce shortages as well as shortages occurring throughout the state's educational programs and public health professions.

Collaborating with partners, as the department has done with its LabAspire program, is critical to the success of any infrastructure

development program. Infrastructure also must be developed strategically, taking into account the state's potential allies, technological advances, and the state public health department's long-term goals. Though still a part of an agency structure, the department is now in a better position to assess its infrastructure needs and communicate those needs to the governor and Legislature.

Recommendation 3: The California Department of Public Health must broaden its efforts to grow and maintain the public health workforce.

- The department should partner with all three public higher education systems to fill the pipeline for public health workers and to educate and link students with public health opportunities at the department.
- The department should, on an ongoing basis, assess workforce needs and identify priority areas based on needs, pipeline capacity, and with an eye toward the future of public health practice. The department should work with the Office of Statewide Health Planning and Development in developing its health workforce data collection system to ensure that public health workforce is included in the process.
- The department should communicate public health workforce needs and proposed solutions directly to the governor and Legislature.

Recommendation 4: The California Department of Public Health should continue to provide leadership to develop the state's laboratory capacity.

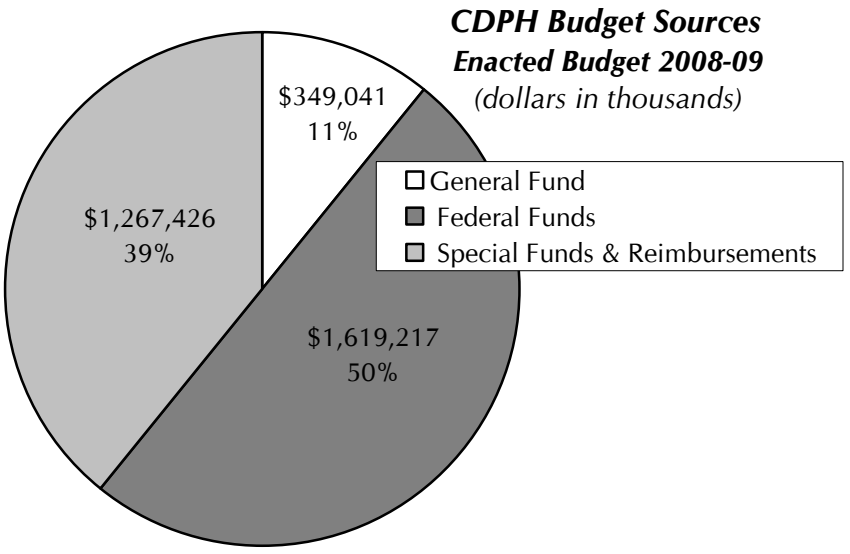
- The department should facilitate consolidation of county laboratories into regional laboratory programs.
- The department should determine its laboratory capacity priorities and ask the governor and Legislature to help lift barriers to workforce development, such as microbiologist salary structures that cannot compete with private and county laboratories.

Funding Limitations and Opportunities

The separation of public health from the health services department, while important for developing public health leadership and infrastructure, also opens opportunities for improving the way public health programs are funded in California.

Until 2007, when the public health department was established, following the money spent on public health was a difficult exercise. Public health functions were interlaced throughout the Department of Health Services, and as a result, funds for these tasks were hard to separate and track on their own.

Despite the difficulty in isolating the total amount of money spent on public health in 2003-04, the Commission found that public health functions, defined as all programs other than Medi-Cal, accounted for $2.8 billion, or 9 percent of the budget authorized for the health services department.[92] In the 2008-09, the public health department received $3.2 billion, or 7.6 percent of the combined budgets for public health and the health care services department that now consists of Medi-Cal, the declining proportion reflecting the growth in Medi-Cal spending. Public health professionals suggest that public health funding is more vulnerable now that it can no longer be shielded from program cuts that previously may have been easier to absorb in a larger combined budget, one where administrative costs, for example, could be spread over several programs.



An independent budget has its advantages: Moving forward, the state will have a baseline for total funds spent on public health activities. This will allow the state to more easily track funding for public health programs, and ultimately, for outcomes.

Funding Sources Set Priorities

The California Department of Public Health has three major sources of revenue: 1) federal funds, 2) special funds and reimbursements, and 3) the state General Fund. Federal fund contributions comprise half of the entire state budget for public health; special funds and reimbursements account for 39 percent, and the remainder, 11 percent, comes from the State General Fund.

Public health experts told the Commission that contribution from the state General Fund is too low compared to the department's overall budget and that the department's General Fund contribution is very low, when compared to General Fund contributions made by other states to their public health operations.[93] The low level of General Fund support as a percentage of the public health department's budget creates a situation where the department's priorities are set by the conditions placed on its major funding streams, limiting the range of options open to the public health officer to set priorities according to his evaluation of the state's needs, especially as those needs shift.

The heavy reliance on federal funds, while minimizing the damage of across-the-board cuts to the state General Fund portion of public health funding, also leaves the department vulnerable to fluctuating federal resources, as is the case with declining federal emergency preparedness funds.

Categorical Funding

Most of the Department of Public Health's expenditures, $2.5 billion in the 2008-09 budget, are made to local health departments in the form of funding tied to specific categories of populations or programs, regardless of local need or priorities. Local health departments, the primary providers of public health programs and services in California, typically receive funds from several sources: state categorical programs, state realignment funding (a portion of sales tax and vehicle license fees), grants and county general funds.[94]

Category-funded programs include projects such as maternal, child, adolescent or family health; environmental health; programs targeting tobacco, nutrition, violence prevention, substance abuse, and injury prevention; vital statistics; and infectious disease control, which encompasses tuberculosis, sexually transmitted diseases, HIV/AIDS, other communicable diseases and epidemiology.[95]

Local departments that receive categorical funds are required to spend the money only on activities allowed by the categorical program and to that extent, they limit the range of program options open to local departments. Categorical funds typically carry reporting and other administrative requirements that require significant staff time within the local jurisdiction. The County Health Executives Association of California surveyed local health departments in 2000 and found that many departments must submit more than 100 fiscal and narrative reports to the state health department. Such extensive reporting requirements mean that staff time is spent on preparing reports and communicating with state personnel on administrative requirements, rather than on public health activities that produce the program's intended results.[96] For its part, the state expends considerable resources reviewing compliance reports and assisting local agencies.

One county public health officer told Commission staff that the categorical funding framework seems designed with the assumption that counties will not use the funds for good public health purposes, so counties must prove to the state, through burdensome reporting requirements, that the funds are being used for its intended purposes. In her small county, she employs four fiscal analysts to comply with the state's reporting requirements, and has declined funds offered by the state because the money came with additional administrative burdens that offset the benefits.[97]

Reporting obligations are generally centered around whether the funds are used appropriately rather than on whether the program is achieving the desired outcome. The state could make better use of these funds by linking them to improved public health outcomes and creating incentives to achieve those outcomes.

Local health officers said that, in addition to administrative burdens created by categorical funding, the categorical programs often lack flexibility that would allow them to use state money more efficiently. Requirements that program services be compartmentalized create conflict when the purpose or funded activity overlaps with other programs. As a result, some activities are duplicated across separate silos. For example, a health educator funded through an HIV/AIDS education program performs some of the same activities as an educator working in a program to reduce sexually-transmitted diseases. Yet these health educators are funded separately and must conduct their activities according to the details of each categorical program, requiring them to be separately focused on their particular program responsibilities.

Reliance on categorical funding "makes it difficult to create cohesive public health strategies to attain our core mission to protect and improve

> ***"… even with limited resources, more can and should be done to streamline existing administrative systems and to speed contract processing and oversight. Programs must have the support and flexibility necessary to do their work and ensure that vital resources can reach the communities for which they are intended."***
>
> Mary Pittman, President and CEO, Public Health Institute. August 21, 2008. Written testimony to the Commission.

the health of our communities," David Souleles, president of the County Health Executives Association of California, told the Commission.[98] Local health departments, as a result, have to find other sources of money to address their unique public health threats or finance ongoing priorities such as chronic disease prevention and management.

The Legislative Analyst's Office, in a report released in February 2008, concluded that "[t]he state's current process for administration and funding of over 30 public health programs at the local level is fragmented, inflexible and fails to hold local health jurisdictions accountable for achieving results."[99] The LAO made the following recommendations to increase flexibility of funding to counties:

- Consolidate certain public health programs into a block grant.
- Enact legislation to direct the public health department to develop a model consolidated contract for other public health programs and use consolidated contracts with counties.
- Develop outcome measures for public health programs.

Consolidation of Categorical Programs in Placer County

Placer County consolidated the following 16 health programs into a single contract:

- California's Children's Services
- Child Health and Disability Prevention Program
- Health Care Program for Children in Foster Care
- Childhood Lead Poisoning Prevention Program
- Immunization Outreach and Education
- Maternal and Child Health
- Adolescent Family Life Program
- Adolescent Sibling Pregnancy Prevention Program
- HIV/AIDS Counseling and Testing
- HIV/AIDS Education and Prevention
- HIV/AIDS Surveillance
- Oral Health, Miles of Smiles
- Preventive Health Care for the Aging
- Sexually Transmitted Disease Control
- Tobacco Control Program
- Women, Infants, and Children Supplemental Nutrition Program

Streamlining Local Public Health Contracts

Representatives of the County Health Executives Association are currently engaged in discussions with the department on strategies to simplify and streamline public health contracting.[100] So far, two counties in California have made an effort to simplify administrative processes.

Placer County sought legislation in 1996 to implement a pilot program to fund health services in an integrated and comprehensive manner. Under the program, which has been in place for five years, the county consolidated 16 categorical programs into a single contract with standard definitions, a single claim process and only one summary report back to the state. Though the consolidation took a significant amount of state public health department and county staff time, it resulted in reduced administrative requirements, better use of staff time and improved accountability by incorporating outcome and performance measures.[101]

Alameda County currently is developing a consolidated contract and estimates that under the proposal now in

development, the 300 hours of staff time the county currently spends to prepare claims for its 20 state-funded programs could be cut by half.[102]

Streamlining Federal Funds

As state funds allocated to local health departments often originate with the federal government, states may have trouble moving from a categorical funding system to one with more flexibility. But the Centers for Disease Control and Prevention (CDC) has demonstrated that it understands the limits imposed by federal funding streams and is moving forward to improve the process.

The CDC introduced its Futures Initiative in 2003, which prioritized its strategies, programs, resources, structure and needs to better respond to 21st-century health threats.[103] One component of the CDC's initiative is the Portfolio Management Project in a dozen states to bridge strategic health goals with federal grant money received by the state and local health agencies.[104]

As part of the project, California is one of two states working closely with CDC officials to draft a Strategic Management Agreement to:

- Engage and align state strategic planning efforts with CDC goals.
- Establish agreed-upon priorities.
- Advance efforts to achieve specific health outcomes.
- Leverage and maximize CDC and state investments.
- Promote program flexibility linked to accountability.[105]

The state's effort to make federal funding more flexible has important potential benefits for California's public health system. And because so much of the money sent by the state to local health departments originates at the federal level, the effort is a critical first step to streamlining categorical funding to local health departments.

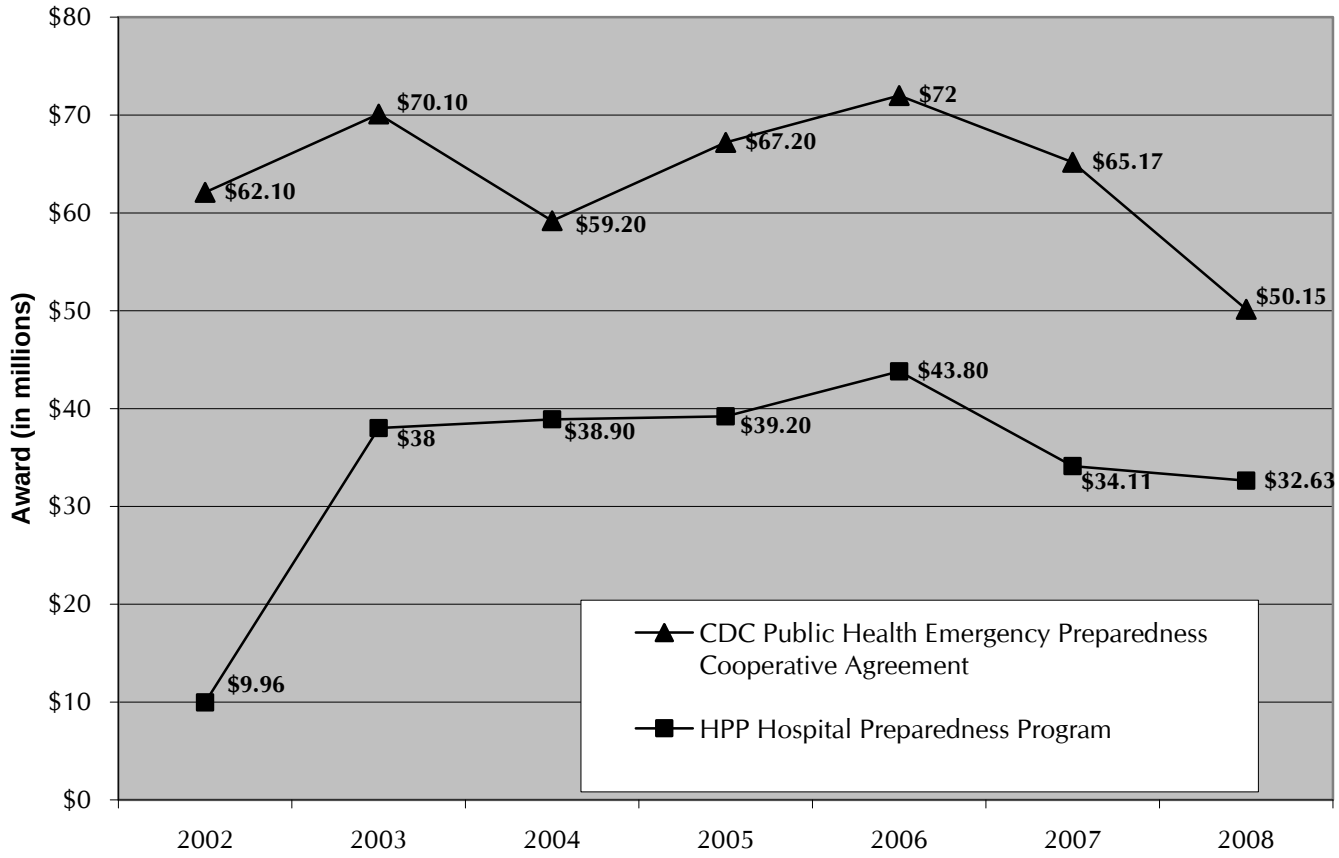
The governor and Legislature should support the department's collaboration with CDC on the strategic management agreement, a key ingredient in California's long-term strategy for improving public health in California.

Shrinking Funds for Emergency Preparedness

Federal funding for public health emergency preparedness to California has declined to $50 million from $72 million in the last two years; hospital preparedness money has been reduced to $33 million from $44 million during the same period.[106]

For the state, as well as for local public health departments, this represents a major challenge as federal money constitutes the bulk of their emergency preparedness operational funding. The state's contribution of $214 million in the 2006-07 state budget represented a one-time outlay for emergency preparedness supplies. The federal emergency preparedness funds the state currently receives are for ongoing costs, mainly emergency preparedness staff at the state and local public health departments.

Federal Public Health Funds Awarded to California



Source: Betsey Lyman. Director. Emergency Preparedness Office. California Department of Public Health. Personal communication. August 5, 2008.

With the infusion of funding for emergency preparedness after 2002 now eroding, many public health programs, emergency preparedness as well as others, find themselves in search of new funding.

Mary Pittman, president of the Public Health Institute, told the commission that "there are still many opportunities for collaborative work to be done on cost avoidance and reduction."[107] In addition to its efforts to streamline funding, the department will need to continue to strategize on how to provide public health to Californians in an era of declining funding, particularly for emergency preparedness activities.

A planning group of state and local public health representatives is currently meeting to discuss planning and priority-setting given the decline in resources and expectation that funding will continue to shrink. The group hopes to develop strategies for integration of emergency preparedness into core public health activities.[108]

As the state public health department seeks ways to maintain its emergency preparedness programs, it should coordinate closely with the new California Emergency Management Agency as it merges the Office of Homeland Security and Office of Emergency Services to ensure their services complement each other and eliminate duplication.

Summary

The public health department is positioned to make great strides in the way public health is funded in California. It has an independent budget that will allow the department to understand and monitor its funding over time, and its leaders are working on a strategic management agreement with CDC to enhance the flexibility of federal funds and program requirements.

The state's system of categorical funding for local public health programs still burdens state and local health departments and creates program silos that inhibit economy and efficiency. While it is prudent for the state to focus first on the federal source of funds, it should move forward on consolidating categorical funding for counties as well, building on the lessons learned from Placer County's contract consolidation.

Recommendation 5: The California Department of Public Health, with the help of the governor and the Legislature, must create more flexible funding mechanisms in order to provide more efficient and effective services to the public.

- The public health department should review its categorically-funded programs and determine which programs could be

consolidated into block grants. Where possible, the department should consolidate program funding and contracts.

- The department should continue to work with the federal government to streamline federal funds coming into the state.

Conclusion

The creation of a new California Department of Public Health is a major step toward improving public health and public safety for the state and for its people. By separating the state's public health functions from its other health and medical insurance programs, the state's policy-makers and public health constituencies can gain a better understanding how the department operates and how it meets the public health needs of Californians. The governor and the Legislature should use the opportunity afforded by this still-fresh start to begin the discussion about what California's public health system *should* look like, clearly defining the roles and responsibilities of state and local players, then ensuring that money is directed in a way that best allows each to fulfill its role.

The Commission has studied California's public health programs repeatedly over the past decade. The creation of a separate public health department was one of its recommendations to bolster the state's ability to respond to a health emergency, whether disease borne or the result of a natural or manmade disaster. To capitalize on the momentum created by the new department, the state should implement the Commission's standing recommendations to make the department a separate agency, whose leader, the state public health officer, reports to the governor. The state public health officer should be an advocate for the public, and can best serve the public by being able to raise uncomfortable issues. The state public health officer should be guided by an independent expert public health board, whose members should be empowered to elect their own chair and who should serve fixed terms.

This board should be tapped to help the department refine its strategies for rebuilding the state's public health infrastructure and workforce and for reducing vacancies in key programs, first among them its state laboratory. The continued erosion of the state's ability to provide quick diagnostic services for counties and hospitals remains a concern. Local agencies rely on the state for backup during disease outbreaks and for tests they are not equipped to conduct. The decision to stop rapid-response testing for multi-drug resistant tuberculosis, relying for testing instead on the federal Centers for Disease Control and Prevention, has alarmed local health officials. The Legislature, in its oversight role, should monitor the outcome of this decision to determine to what extent, if any, its makes California, which already has the nation's largest

tuberculosis caseload, more vulnerable to multi-drug resistant tuberculosis.

The LabAspire program is a first step in developing a new cohort of future local public health laboratory directors. As structured, however, LabAspire is not producing the necessary return on the state's $2.5 million investment. Its two graduates so far failed to join the state public health service. It needs to be improved and its incentives redesigned to steer graduates toward careers as public health laboratory directors. The department needs to think more broadly about how to develop its workforce and the Commission is encouraged by its creation of a project team for this task, which it should undertake with urgency.

State public health leaders should broaden this discussion, tapping the expertise on its current advisory committee, or future public health board, to determine what the appropriate roles are for the state department of public health and for local public health departments and what capacities truly are needed for each partner to fulfill its role. Advances in medicine mean that many diseases can be treated more quickly and effectively, stopping an outbreak that in earlier days would have posed a far more serious public health threat. These advances have been complemented by a revolution in communications technology that has the potential to link all parts of the state for real-time monitoring and response. California cannot return to the same kind of public health system it had decades ago. More important, it might no longer need to. Regionalizing local laboratories is a politically sensitive subject, and best done when local governments decide for themselves it is the right move. Yet to a great extent, it already is happening for certain types of tests. Any such discussion should recognize the importance of the role for local labs to serve local public health needs, as well as their public safety role as disease sentinels for the state as a whole. This discussion must start this year.

Moving the public health budget out of the larger Department of Health Services improved transparency, allows better tracking of program spending and ultimately may help the department align spending with the specific outcomes it wants to achieve. Separating the budget also reveals the extent to which the department's spending – and through it, local health department spending – is determined by streams of money tied to specific programs and populations, often from federal sources with federal requirements.

The state, through its General Fund, makes a comparatively small investment of its own in the programs designed to promote health, prevent the spread of disease and protect against threats of biological terrorism. To the extent that the governor and Legislature have chosen

to allocate more of the state's public safety dollars to other priorities, it has ceded some of its ability to set more of the state's agenda for public health.

The department should be credited for working with federal officials to streamline categorical funding, which ultimately should improve flexibility for its own funding distributions to local health departments. This is the first step in what likely will be a long process. It is a recognition that in the absence of more money, more flexibility may be the next best option. Using this flexibility to create incentives should be the next step. The department should use greater funding flexibility to link funding to outcomes that increase public health and enhance public safety.

The California Department of Public Health's first anniversary should not be considered a finish line. The Commission's decision to study the department's progress at the end of its first year was intended as a check up, with the expectation that it will continue to develop and progress. The first year in any new organization is a tumultuous time, and the department emerged from this period only to enter a sophomore year of unprecedented fiscal turmoil. In this time of uncertainty, Californians are fortunate to have such dedicated and professional employees protecting public safety and public health.

The Commission's Study Process

The Commission previously examined the California's level of emergency preparedness in its 2002 study, *Be Prepared: Getting Ready for New and Uncertain Dangers*. In subsequent reports, the Commission focused more narrowly on the state's public health system and issued recommendations for enhancing public health in its 2003 report, *To Protect and Prevent: Rebuilding California's Public Health System* and in its 2005 report, *Recommendations for Emergency Preparedness and Public Health*.

The Commission initiated this study in the summer of 2008 to assess the accomplishments of the new Department of Public Health one year after its separation from the former Department of Health Services and to provide input and guidance as the new department takes root. This study also served as an opportunity for the Commission to follow-up on the progress that has been made in implementing its other prior public health recommendations and to determine what additional actions are necessary.

As part of the study, the Commission convened a public hearing in August 2008. The Commission heard from a number of public health experts, including the Department of Public Health director and state public health officer, local health officers and representatives from public health associations. Hearing witnesses are listed in Appendix A.

The Commission also convened a subcommittee meeting and an advisory committee meeting during the course of this study. At the subcommittee meeting, held in August 2008, Commissioners met with officials at the California State Public Health Laboratory in Richmond, California to learn about the state public health laboratory system. The advisory committee meeting, also held in August 2008, brought together public health leaders from across the state to discuss issues surrounding the state's public health workforce, including challenges with recruitment and retention, the efforts to address those challenges and recommendations for improvement. A list of experts who participated in the Little Hoover Commission public meetings is included in Appendix B.

Commission staff received valuable feedback from a number of experts representing various components of California's public health system. The Commission greatly benefited from the contributions of all who

shared their expertise, but the findings and recommendations in this report are the Commission's own.

All written testimony submitted electronically for each of the hearings, and this report is available online at the Commission Web site, www.lhc.ca.gov.

Appendices & Notes

- ✓ ***Public Hearing Witnesses***
- ✓ ***Little Hoover Commission Public Meetings***
- ✓ ***Notes***

Appendix A

Little Hoover Commission Public Hearing Witnesses

Witnesses Appearing at Little Hoover Commission Public Hearing on Public Health, August 28, 2008

Mark B. Horton, Director and Public Health Officer, California Department of Public Health

Betsy Imholz, Director of Special Projects, Consumers Union

Mimi Lachica, Long Beach Health Laboratory Director; President, California Association of Public Health Laboratory Directors

Ann Lindsay, President, California Conference of Local Health Officers; Health Officer, Humboldt County Department of Health and Human Services

Giorgio Piccagli, President, California Public Health Association – North

Mary Pittman, President, Public Health Institute

David Souleles, President, County Health Executives Association of California

Appendix B

Little Hoover Commission Public Meetings

Public Health Subcommittee Meeting – August 21, 2008
California State Public Health Laboratory Capacity

Jean Iacino, Assistant to the Director, California Department of Public Health

Paul Kimsey, Deputy Director, Office of the State Laboratory, California Department of Public Health

Bonita Sorensen, Chief Deputy Director of Policy and Programs, California Department of Public Health

Public Health Advisory Committee Meeting – August 21, 2008
California's Public Health Workforce

Adele Amodeo, Executive Director, California Public Health Association – North

Catherine Dower, Associate Director, Center for Health Professions, UC San Francisco

Bruce Fujikawa, Director, San Mateo County Laboratory; former President, California Association of Public Health Laboratory Directors

Mimi Lachica, Director, Long Beach Health Laboratory; President, California Association of Public Health Laboratory Directors

Paul Kimsey, Deputy Director, Office of the State Laboratory, California Department of Public Health

Poki Namkung, Health Officer, Santa Cruz Health Services Agency; former President, National Association of County and City Health Officials

Jeff Oxendine, Director, Center for Public Health Practice, UC Berkeley School of Public Health

Giorgio Piccagli, President, California Public Health Association – North

Janey Skinner, Director, Regional Health Occupations Resource Center, City College of San Francisco

Bonita Sorensen, Chief Deputy Director of Policy and Programs, California Department of Public Health

Notes

1. Little Hoover Commission. April, 2003. "To Protect and Prevent: Rebuilding California's Public Health System."
2. Lester Breslow, Dean Emeritus, UCLA School of Public Health, and Philip R. Lee, Professor of Social Medicine (Emeritus) Department of Medicine and Director and Senior Advisor, Institute for Health Policy Studies, UCSF School of Medicine. October 24, 2002. Written testimony to the Commission.
3. Little Hoover Commission. January, 2002. "Be Prepared: Getting Ready for New and Uncertain Dangers."
4. Little Hoover Commission. April, 2003. "To Protect and Prevent: Rebuilding California's Public Health System." Also, Little Hoover Commission. June 23, 2005. Letter to the Governor and Legislature. "Recommendations for Emergency Preparedness and Public Health."
5. Little Hoover Commission. See endnote 1.
6. Little Hoover Commission. June 23, 2005. Letter to the Governor and Legislature. "Recommendations for Emergency Preparedness and Public Health."
7. Little Hoover Commission. April, 2006. "Safeguarding the Golden State: Preparing for Catastrophic Events."
8. SB 162 (Ortiz), Chapter 241, Statutes of 2006.
9. Dr. Mark Horton, State Health Officer and Director, California Department of Public Health. Sacramento, CA. August 28, 2008. Written testimony to the Commission.
10. Dr. Mark Horton. See endnote 9.
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